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### Birth Pangs: Maternity, Medicine, and Feminine Delicacy in English Canada, 1867-1950

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BIRTH PANGS:  
MATERNITY, MEDICINE, AND FEMININE DELICACY  
IN ENGLISH CANADA,  
1867-1950

by  
Whitney Wood

Honours Bachelor of Arts (History) Lakehead University, 2009  
Master of Arts (History) Lakehead University, 2010

A Dissertation  
submitted to the Faculty of Arts

in partial fulfillment of the requirements for the degree of  
Doctor of Philosophy in History

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## **Abstract**

The pain women experience in giving birth is a universal, cross-cultural, biological reality. The ways women experienced these pains, as well as the ways they were perceived by physicians and depicted in wider medical discourses, however, are historically and culturally specific. In late nineteenth and early twentieth century English Canada – a key period in terms of both the medicalization of birth and the professionalization of obstetrics – the dominant medical perception of the female body held that white, middle-class, and urban-dwelling women were particularly “delicate” and sensitive to pain for a variety of reasons. Drawing on a broad range of archival and print sources including medical textbooks, course calendars, lecture notes, professional medical journals, popular advice literature, diaries, and private correspondence, this dissertation unpacks the medical construction of the “delicate woman”, examining the evolution of these ideas and their impact. I argue that the variety of gendered, class-based, and racialized distinctions that underpinned the construction of female “delicacy” and sensitivity to pain were inseparable from turn-of-the-twentieth century social and cultural tensions. Medical rhetoric and perceptions of the delicate woman – as well as the increasingly pathological views of both pregnancy and birth that were inherently connected with this particular construction of the female body – contributed to a new type of birth experience for many women during these transformative decades. While the growing popularity of natural childbirth ideologies in the 1940s and 1950s represented some of the first substantial and organized opposition to the medicalization of childbirth that had been ongoing since the second half of the nineteenth century, proponents of natural birth ultimately continued to articulate conservative views of the female body, birth, and the doctor-patient relationship.

## Acknowledgements

In completing this project, I have been incredibly fortunate to have the support of excellent scholars, generous funding organizations, and an always encouraging group of friends and family. First and foremost, my greatest thanks go to my supervisor, Cynthia Comacchio. Since taking me on as a PhD student in the Fall of 2010, Cindy has been an enduring source of guidance and advice, reading countless funding applications, conference papers, and chapter and article drafts, and providing me with feedback that always seemed to strike the perfect balance of kindness, encouragement, and frankness. Cindy had faith in my abilities even when it was near impossible to see the light at the end of the tunnel, and pushed me to finish this dissertation in time to move on to new opportunities. I absolutely cannot thank her enough. Over the past five years, it has also been a pleasure to work alongside my two committee members, Wendy Mitchinson and Tracy Penny Light. As her scholarship has played a major role in inspiring my own research into the history of childbirth, Wendy's involvement with this project was a natural choice, and I was thrilled to learn that she was willing to join my committee. Her feedback at critical junctures was invaluable in shaping the trajectory of this study, and her willingness to read funding applications and provide letters of reference has been greatly appreciated. Tracy Penny Light has been an ongoing source of enthusiasm and support since my time as a first year PhD student in her "History of Medicine" doctoral seminar. She has been a joy to work with over the past five years, and I appreciate both her keen historical insight on the issues I explore in this dissertation, and her broader passion for teaching and lifelong learning, which has done much to inspire my own work in the classroom. I look forward to the chance to work alongside these inspiring women in the years to come. Many thanks also go to Penelope Ironstone and Mona Gleason for their willingness to serve on my dissertation examination committee.

Outside of the Tri-University Graduate Programme, I continued to benefit from the support and guidance of a growing group of academics. At Lakehead University, Kristin Burnett, Geoff Hudson, and Patricia Jasen continued to support both me and my work in various ways. Special thanks go to Geoff for inviting me back to Thunder Bay to share my ideas with the Northern Ontario School of Medicine History of Health and Medicine Group. Throughout my time as a PhD student, Jane Nicholas provided a great deal of enthusiasm and support, writing reference letters and offering me a chance to

work with her on her own projects. While I was unfortunate to leave Waterloo just as she arrived, I look forward to continuing to collaborate with her in the years to come.

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Of course, I need to thank my own families for their ongoing support. The Asmussens – Brenda and Kim, Matt and Susan, and Christina – have welcomed me into their family and their home more times than I can count, and I am happy to be able to add my own dissertation to the growing stack under their coffee table. My parents, Carol and Dan, and my sisters, Madison and Hillary, have been nothing but encouraging throughout this entire process. Though visits were sometimes few and far between, they regularly enquired as to my progress, asked what I had on my plate in terms of “homework,” and, perhaps most importantly, cheered me on and encouraged me to finish. My Mom deserves special mention for reading every word of this dissertation and much of what I have written over the past five years. My “Grammy,” Maybelle Weberg (1929-2010), was here to see the beginnings of this process, but not the end. For all of her talk of “tonics” – perhaps my earliest introduction to the history of medicine – it is only fitting that I dedicate this study to her.

And finally, thanks to Mike Asmussen, who has been the best partner I could possibly ask for throughout both the life of this project and the past ten years. His work ethic and dedication to completing his own PhD were nothing short of inspiring. Mike, you were an unwavering source of support, and celebrated my accomplishments with me at every turn. Thanks for understanding the pressures of this process, providing much needed breaks, and (almost) always cooking dinner and picking up the beer.

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## **List of Abbreviations**

AO – Archives of Ontario

BAJMPS – *British American Journal of Medical and Physical Science*

CHJ – *Canadian Home Journal*

CJMS – *Canadian Journal of Medicine and Surgery*

CJPH – *Canadian Journal of Public Health*

CL – *Canada Lancet*

CLP – *Canada Lancet and Practitioner*

CMAJ – *Canadian Medical Association Journal*

CMJ – *Canada Medical Journal and Monthly Record of Medical and Surgical Science*

CMR – *Canada Medical Record*

CMS – Canadian Mothercraft Society

CP – *Canadian Practitioner*

CPHJ – *Canadian Public Health Journal*

DMM – *Dominion Medical Monthly and Ontario Medical Journal*

LAC – Library and Archives Canada

NBTF – National Birthday Trust Fund

PHJ – *Public Health Journal*

QMQ – *Queen's Medical Quarterly*

TCMR – *The Canadian Medical Review*

WCMJ – *Western Canadian Medical Journal*

UTMJ – *University of Toronto Medical Journal*

## Introduction

In January 2012, an article published in *The Globe and Mail* posed the question, “Do women feel more pain than men?” The article summarized a recent study, published in *The Journal of Pain*, that presented the findings of Stanford University researchers who analyzed electronic medical records indicating the pain scores of over ten thousand patients. The researchers found that, for the majority of ailments – from back and neck pain, to inflammation, hypertension, and even sinus infections – women reported significantly higher levels of pain (approximately twenty percent higher) than men. Thus, the *Globe* writers’ response to the question was “they think they do,” confirming that women consistently perceive themselves as the more sensitive sex.<sup>1</sup>

While contemporary scientific research supports the importance of gender-specific approaches to understanding and treating bodily pain, the premise behind such studies is by no means new. Pain is not simply a symptom, or outcome, of physical or emotional trauma – it is also socially constructed and historically contingent. Ideas about women’s physical and mental inferiority reflect and reinforce perceptions of how women experienced and continue to experience pain, views that often defined them as weak, vulnerable, and predisposed to illness. These conceptualizations of women’s pain, in turn, justified restrictions on women’s roles, rights, and activities. In other words, much is at stake in representing women as the more sensitive sex. Though scholars have

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<sup>1</sup> Wendy Leung, “Do women feel more pain than men? They think they do, says study,” *The Globe and Mail*, 24 January 2012. See also Tara Parker-Pope, “In Rating Pain, Women are the More Sensitive Sex,” *New York Times*, 23 January 2012, and David Ruau, Linda Y. Liu, J. David Clark, Martin S. Angst and Atul J. Butte, “Sex Differences in Reported Pain Across 11,000 Patients Captured in Electronic Medical Records,” *The Journal of Pain* 13, no. 3 (March 2012, published online 16 January 2012), pp. 228-234.

increasingly recognized that individual experiences of pain are shaped and represented by prevailing ideas about gender, class, race, and age in any historical moment, the broader implications of such discourses are all too often overlooked. This dissertation, then, contributes to the nascent historiography surrounding the gendered experiences of, and attitudes toward pain, in English Canada during the years between 1867 and 1950.

While pain is central to the human experience, it is not universally experienced by individuals in different cultures.<sup>2</sup> Labour pains are unique and distinguishable from other types of bodily pains in that they are both dreaded and desired by expectant women. The pain women experience in giving birth is a universal, cross-cultural, biological reality. The ways in which women have experienced these pains, as well as the ways in which they were perceived by physicians and depicted in wider medical discourses, however, are fundamentally historical as well as cultural. In late nineteenth and early twentieth century English Canada, the dominant medical perception of the female body held that white, middle and upper-class, urban-dwelling women were particularly “delicate” and sensitive to pain for a variety of reasons. The gendered, class-based, and racialized arguments that upheld representations of this “delicate woman” were intimately connected with the period’s interrelated social anxieties. During these transformative decades, giving birth, historically one of the central focuses of womanly culture, came to be shrouded in new levels of fear and anxiety. At the same time, childbirth was becoming

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<sup>2</sup> This point has been aptly made by recent historians of pain. See Louise Hide, Joanna Bourke, and Carmen Mangion, “Introduction: Perspectives on Pain,” *19: Interdisciplinary Studies in the Long Nineteenth Century* 15 (2012), pp.1-8.

medicalized and increasingly controlled by men more so than women.<sup>3</sup> The result was, for many women, a new type of birth experience.

This study begins to “unpack” these ideas, examining their evolution and their impact in late nineteenth and early twentieth century English Canada. Physicians, largely male, were the foremost proponents of the idea that these women, described by one doctor as “the luxurious daughters of artificial life,” were increasingly sensitive to pain, specifically during parturition.<sup>4</sup> They were inculcated with these ideas in the often limited obstetrical training they received as medical students and perpetuated them in the training they offered to their own medical students. Physicians articulated a specific set of values relating to feminine sensitivity in their own professional discussions and debates, and were particularly effective in disseminating these ideas in the prescriptive works they authored. As Martin Pernick has suggested in his study of the use of anaesthesia in late nineteenth century America, these ideas about gendered sensitivities affected how and when physicians used anaesthesia in their obstetric practices.<sup>5</sup> And, perhaps most significantly, physicians’ ideas about female sensitivity and obstetric pain affected how women viewed their own bodies and birth experiences, as well as their expectations for

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<sup>3</sup> Fear of childbearing was by no means new, but women’s anxieties certainly appear to have intensified during this period. With the fracturing of traditional female support networks and increases in physician-assisted birth, women’s anxieties became more public and visible. At the same time, medical writings on childbirth that both relied on and fuelled women’s anxieties surrounding parturition were published at unprecedented rates. For more on this phenomenon, see Hilary Marland, “Languages and Landscapes of Emotion: Motherhood and Puerperal Insanity in the Nineteenth Century,” in Fay Bound Alberti, *Medicine, Emotion and Disease, 1700-1950* (New York: Palgrave MacMillan, 2006), pp. 53-78.

<sup>4</sup> M.L. Holbrook, *Parturition without Pain: A Code of Directions for Escaping from the Primal Curse* (Toronto: Maclear and Company, 1875), p. 17.

<sup>5</sup> Martin Pernick, *A Calculus of Suffering: Pain, Professionalism and Anaesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985).

their “confinement,” itself a word that implies imposed, and possibly painful, physical restraint.

This project considers a number of core questions. First, what was the broader cultural milieu that allowed ideas about the delicate female body to emerge and take hold in English-Canadian society? How did these ideas about feminine delicacy underpin the ways in which English-Canadian physicians described the bodies, pregnancies, and births of various groups of women? How did medical professionalization, as witnessed by the establishment of the Canadian Medical Association in 1867, shape ideas about women, pain, and childbirth? How then did physicians, by and large men, circulate these ideas in both professional and wider public arenas? What impact did these ideas – and, most notably, the growing pathologization of pregnancy and birth – have on the development and use of a growing obstetric anaesthesia arsenal that encouraged medical intervention during childbirth? Finally, and integral to this study, how did women react to developments in medical theory and practices, and to their resultant discourses, both professional and public? Can we get a sense of how women’s own ideas about their bodies and birth experiences were shaped by these medical views and approaches to the act of giving birth, which was supposed to be the defining experience of their lives?

These questions will be addressed in relation to medical education, physicians’ professional discourses, the prescriptive literature, the gradual but steady shift from home to hospital births, and women’s own ideas about childbirth, and consequently, about pain and its management. The broader sociocultural context found in gendered, class-based, and racialized power relations, manifested in medical-lay and (male) doctor-(female) patient power relationships, plays an important role. Physicians regularly distinguished

between and differentiated the bodies of their female patients based on these categories, articulating perceived gender, class, and racial differences, essentializing women's bodies, pregnancies, and experiences of the sensations and pains of giving birth.<sup>6</sup> I argue that the conceptualization of women's pain during parturition, and, more generally, how women experience childbirth, is contingent with the social constructions of womanhood at any given moment and is inseparable from the wider cultural currents of the time. Medical and cultural ideas about women's "birth pangs" both contributed to and were a product of mounting class, gender, ethnic, and racial anxieties in late nineteenth and early twentieth century English Canada. Medical conceptualizations of maternity and feminine delicacy acquired special significance during this period of ongoing change.

### Writing Female Bodies, Births, and Birth Pangs: A Historiographical Examination

#### *Bodies*

This study of "birth pangs" is rooted in several diverse but complementary bodies of historical scholarship. The historiographies I draw upon in framing this project range from the broad to the very specific. Scholarship on the history of the body, women's health and reproduction (including the history of childbirth), and the history of pain stand

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<sup>6</sup> In his 1920 series of case studies, Charles M. Green, Professor Emeritus of Obstetrics and Gynaecology at Harvard University, for example, regularly described his female patients as "cultivated" or "intelligent," citing the professions of their fathers as evidence of a "refined" upbringing. The racial and ethnic backgrounds of those patients who could have been considered as non-white appear to have been consistently and explicitly identified. Charles M. Green, *Diseases of Women Including Abnormalities of Pregnancy, Labor, and Puerperium: A Clinical Study of Pathological Conditions Characteristic of the Five Periods of Woman's Life (Presented in One Hundred and Seventy-Three Case Histories)* (Boston: W.M. Leonard, 1920), pp. 227, 243, 250, 265.

out as three major areas of interest. In the following pages, each of these three areas, in turn, will be briefly examined.

Since the publication and translation of Michel Foucault's landmark *Discipline and Punish* and *The History of Sexuality* in the late 1970s, historians and interdisciplinary scholars alike have been increasingly attuned to poststructuralism and how the intersections between bodies, power, and surveillance have played out in their work.<sup>7</sup> It was the 1980s, however, that saw the emergence of a distinct group of scholars positioning themselves in the emerging field of "body studies." Spearheaded by sociologist Bryan Turner, who, in his 1984 work, *The Body and Society: Explorations in Social Theory*, called for "renewed attention to the body," this group sought to give bodies a central place in anthropological, historical, sociological, and literary scholarship.<sup>8</sup> Aside from a favourably received collection of essays edited by Catherine Gallagher and Thomas Laqueur published in 1987,<sup>9</sup> one of the first major contributions to the historiography of the body came from the late and very prolific British medical historian Roy Porter. In his examination of "The History of the Body," originally published in 1992, Porter cautioned that "the history of the body must give way to histories of bodies," in all cases, but especially when studying the bodies of women.<sup>10</sup> By

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<sup>7</sup> Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books, 1977), and Michel Foucault, *The History of Sexuality Volume I: An Introduction* (New York: Vintage Books, 1978).

<sup>8</sup> Bryan Turner, *The Body and Society: Explorations in Social Theory* (Oxford: Blackwell Publishing, 1984).

<sup>9</sup> Catherine Gallagher and Thomas Laqueur, eds. *The Making of the Modern Body; Sexuality and Society in the Nineteenth Century* (Berkeley: University of California Press, 1987).

<sup>10</sup> Roy Porter, "The History of the Body Reconsidered," in *New Perspectives in Historical Writing*, 2<sup>nd</sup> Edition, Ed. Peter Burke (University Park, PA: The Pennsylvania State University Press, 2001), p. 237.

the early 1990s, then, “the body” had been introduced to the historical profession as both a site and means of analysis.

Within the Canadian historiography, the early 1990s also saw a series of debates surrounding the best way to write Canadian history. At one end of the spectrum, well-established scholars including Jack Granatstein and Michael Bliss took issue with historians’ increasing attention to “non-national connections” including region, ethnicity, class, family, and gender. They criticized scholars who framed their studies around these categories of analysis – including, notably, those studying the history of women – for contributing to the growing divide between academic historians and the reading public.<sup>11</sup> On the other side of the divide, casting Bliss and Granatstein’s position as “an attack upon feminists’ requests for a new history which includes the experiences of women, minorities, and working people,” feminist historians including Linda Kealey, Ruth Roach Pierson, Joan Sangster, and Veronica Strong-Boag suggested that the “national history” at risk of being “torn asunder” was by no means an inclusive one.<sup>12</sup> As women’s and social histories often focused on individual experiences of race, class, and gender – and how such factors or categories were embodied – bodies, and especially the bodies of women, were implicitly at the centre of these debates. When national historians on one side of the divide singled out “the housemaid’s knee in Belleville in the 1890s” as an

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<sup>11</sup> Michael Bliss, “Privatizing the Mind: The Sundering of Canadian History, the Sundering of Canada,” *Journal of Canadian Studies* 26, no. 4 (Winter 1991-92), pp. 6, 11. See also J.L. Granatstein, *Who Killed Canadian History?* (Toronto: Harper Collins, 1998).

<sup>12</sup> Linda Kealey, Ruth Pierson, Joan Sangster, and Veronica Strong-Boag, “Teaching Canadian History in the 1990s: Whose ‘National’ History Are We Lamenting?” *Journal of Canadian Studies* 27, no. 2 (Summer 1992), pp. 129-130.



example of the easily dismissed and, perhaps, “trivial” work being done by those in the other camp, the female body occupied an explicit place in these discussions.<sup>13</sup>

In the years since, Canadian historians have paid increasing attention to these subjects. While many have made significant contributions to our historical understandings of how race, class, and gender (among other categories) are embodied, few have explicitly associated their work with the “history of the body” as a field, adopting “the body” as the primary point of analysis. Though masculinity and male bodies have garnered increasing interest from historians in recent decades,<sup>14</sup> and the bodies of children are the subject of new and exciting studies,<sup>15</sup> much of the existing literature has focused on the female form. Emphases on the historical regulation of both

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<sup>13</sup> Christopher Moore, “The Organized Man,” *The Beaver* 71 (April-May 1991), p. 59. Historians Patrizia Gentile and Jane Nicholas argue that the repeated dismissal of the “housemaid’s knee” was revealing in that “ridicule from some national historians seemed to point directly at working-class women’s bodies, as if they were somehow trivial to the country’s history.” Jane Nicholas and Patrizia Gentile, “Introduction: Contesting Bodies, Nation, and Canadian History,” in *Contesting Bodies and Nation in Canadian History*, eds. Patrizia Gentile and Jane Nicholas (Toronto: University of Toronto Press, 2013), p. 10.

<sup>14</sup> Christopher Dummitt’s *The Manly Modern: Masculinity in Postwar Canada* (Vancouver: University of British Columbia Press, 2007) stands out as perhaps the most well-known example of the past decade.

<sup>15</sup> Mona Gleason has explored how psychologists and educators – and, in her most recent monograph, health professionals – have regulated children’s bodies and behaviours in twentieth century Canada. See Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999) and *Small Matters: Canadian Children in Sickness and Health* (Montreal and Kingston: McGill-Queen’s University Press, 2013). For a diverse examination of how the health experiences bodies of Canadian youngsters were variously impacted by age, (dis)ability, class, race, region, and religion (among other factors), see *Children’s Health Issues in Historical Perspective*, eds. Cheryl Krasnick Warsh and Veronica Strong-Boag (Waterloo: Wilfrid Laurier University Press, 2005).

deviant and “normal” bodies,<sup>16</sup> the value of women’s reproductive bodies,<sup>17</sup> and parallels between bodies and the nation stand out as recurring themes.<sup>18</sup>

In terms of those scholars explicitly positioning themselves within the field of “body studies”, the works of historians including Wendy Mitchinson, Cynthia Comacchio, Mary-Ellen Kelm, Mona Gleason, James Opp, and, most recently, Jane Nicholas, stand out as particularly noteworthy Canadian examples. Mitchinson’s many contributions are discussed in the following pages as they relate to the historiography of women’s health and reproduction. In her 1994 work, *Nations are Built of Babies: Saving Ontario’s Mothers and Children, 1900-1940*, Comacchio argued that ensuring the health of both mothers and infants was increasingly framed as “a matter of national importance” in early twentieth century Canada, especially as wartime tensions escalated. By emphasizing “optimal labour efficiency” – in this case, women’s efficient reproduction of healthy offspring – reformers strengthened the connections between individual bodies and the nation.<sup>19</sup> Comacchio’s focus on the body was strengthened in her 1998

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<sup>16</sup> In an early contribution to the field, Veronica Strong-Boag, for example, focused on how the lives and bodies of girls and women were regulated throughout the life cycle. Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Markham: Penguin Books, 1988). For a more recent example of this regulation see Mary Louise Adams, *The Trouble with Normal: Postwar Youth and the Making of Heterosexuality* (Toronto: University of Toronto Press, 1997).

<sup>17</sup> See the following section of this brief historiographical discussion.

<sup>18</sup> Mariana Valverde’s *The Age of Light Soap and Water* stands out as one example. Here, Valverde unpacked racialized discourses of moral reform and sexuality in late-nineteenth and early-twentieth century English Canada to argue that reformers’ discussions of physical and sexual hygiene, relying on ever-present metaphors of “cleanliness” associated purity with whiteness and drew parallels between the health of individual bodies and the nation as a whole. Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: University of Toronto Press, 1991), p. 32. See also Gentile and Nicholas, *Contesting Bodies and Nation in Canadian History*.

<sup>19</sup> Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario’s Mothers and Children, 1900-1940* (Montreal and Kingston: McGill-Queen’s University Press, 1993).

examination of the “human machinery” of industrial Canada, in which she deftly demonstrated medicine’s increasing reliance on mechanistic metaphors and argued that “different priorities of production and reproduction have left their mark even on the body’s seemingly-immutable physical boundaries.” As the state placed increasing emphasis on healthy reproduction, the machinery of the body was increasingly gendered, with women’s bodies cast as at once defective – in that they were weaker and less efficient than the bodies of men – and superior – in that they had the capacity to reproduce. For industrial reformers, this “reality” placed the bodies of women “in special need of ‘management’, yet specially equipped them for the ‘management’ of household and family.”<sup>20</sup> Mary-Ellen Kelm’s *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (1998) marked another substantial addition to the Canadian historiography on bodies and embodiment in the late 1990s. Explicitly positioning herself within this emerging field, Kelm’s recognition of the socially and culturally constituted nature of the body was integral to her argument that the “re-shaping and re-formation” of Aboriginal bodies was “central to the processes of colonization in British Columbia.”<sup>21</sup> Around the same time, Mona Gleason, a historian of childhood and youth, made an important contribution to the field by arguing that the bodies of Canadian children existed as an important site “upon which the sometimes competing negotiations of adults and children were negotiated and mediated.”<sup>22</sup> James Opp’s *The Lord for the Body: Religion,*

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<sup>20</sup> Cynthia Comacchio, “Mechanomorphosis: Science, Management, and ‘Human Machinery’ in Industrial Canada, 1900-1945,” *Labour/Le Travail* 41 (Spring 1998), pp. 36, 50.

<sup>21</sup> Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1998), p. 177.

<sup>22</sup> Mona Gleason, “Embodied Negotiations: Children’s Bodies and Historical Change in Canada, 1930 to 1960,” *Journal of Canadian Studies* 34, no. 1 (1999), p. 114. Gleason continued to explore how “embodied markers,” including size and age, “structured relationships between the

*Medicine, and Protestant Faith Healing in Canada, 1880-1930*, published in 2005, took a new approach, offering an alternative way of viewing the body that existed as an important counterpoint to hegemonic medical conceptualizations – both past and present. Here, Opp probed some of the many understudied intersections between medicine and religion, and, recognizing that “the first step in recovering a history of faith healing is to recognize that it is actually a history of the body that is being pursued,” highlighted the variety of ways in which faith healers resisted medical discourse and authority as the two “rival priesthoods” competed to conceptualize and control the body.<sup>23</sup>

In her 2007 assessment of the field, Lisa Helps argued that although “bodies do appear, flesh out arguments, and make class relations and processes of gendering and racialization more tangible” in many recent works by Canadian historians, studies in which “the authors formulate the arguments and analyses *through the body*, that is, recent works in which the body is the central site of investigation,” are significantly harder to come by.<sup>24</sup> While the work of those scholars discussed above stands out as exceptions to Helps’ assessment, the “corporeal turn”, underway in other areas of the social science and humanities since the mid-1990s, remained incomplete in the Canadian historiographical context. Despite recent and noteworthy contributions to the field including edited collections from Patrizia Gentile and Jane Nicholas,<sup>25</sup> and Tracy Penny Light, Barbara

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generations and the differentials of power that sustained them” in her 2013 monograph. Gleason, *Small Matters*, p. 14.

<sup>23</sup> James Opp, *The Lord for The Body: Religion, Medicine, and Protestant Faith Healing in Canada, 1880-1930* (Montreal and Kingston: McGill-Queen’s University Press, 2005), pp. 6-9, 12, 210.

<sup>24</sup> Lisa Helps, “Body, Power, Desire: Mapping Canadian Body History,” *Journal of Canadian Studies* 41, no. 1 (Winter 2007), p. 127.

<sup>25</sup> Gentile and Nicholas, *Contesting Bodies and Nation in Canadian History*.

Brookes, and Wendy Mitchinson<sup>26</sup> – as well as Nicholas’ recent book-length study highlighting the ways in which the Modern Girl of the 1920s engaged with the politics of beauty and the body<sup>27</sup> – this is still the case. Seeking to contribute to this growing body of scholarship and continue the corporeal turn, women’s bodies are at the heart of my project, just as ideas about women’s embodied experience(s) of pregnancy and pain during childbirth were a core component of physician-patient encounters throughout the late nineteenth and early twentieth centuries.

### *Births and Birth Pangs*

The historiography on women and health has necessarily given childbirth a central place. One of the earliest contributions to the field, Edward Shorter’s *Women’s Bodies: A Social History of Women’s Encounter with Health, Ill-Health, and Medicine*, first published in 1982, offered an important historical examination of new subject matter, but essentially held that women in the past were victims of their own anatomy, and were, in effect, rescued by medicine and medical professionals.<sup>28</sup> Some of the early feminist histories of medicine, on the other hand, tended to vilify physicians, portraying them as a monolithic and even misogynistic group. In her 1984 study, *The Captured Womb*, British historian Ann Oakley, for example, argued that prenatal care for pregnant women facilitated “the capturing of women’s wombs...the domination of the physicalist

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<sup>26</sup> Tracy Penny Light, Barbara Brookes, and Wendy Mitchinson, eds. *Bodily Subjects: Essays on Gender and Health, 1800-2000*. (Montreal and Kingston: McGill-Queen’s University Press, 2015).

<sup>27</sup> Jane Nicholas, *The Modern Girl: Feminine Modernities, The Body, and Commodities in the 1920s* (Toronto: University of Toronto Press, 2015), p. 11.

<sup>28</sup> Edward Shorter, *Women’s Bodies: A Social History of Women’s Encounter with Health, Ill-Health, and Medicine* (New York: Basic Books, 1982).

and masculinist scientific paradigm.” For Oakley, the most significant aspect of such care was, and remains, “the clinical insistence on the probability of pathology in all childbearing” as part of a wider medical strategy to control the parturient female body.<sup>29</sup>

Subsequent studies moved beyond these dichotomies, and, recognizing that women were not wholly the victims of their bodies nor medical tyrants, shifted the focus to doctor-patient relations, complicating the historical picture and opening the way to more sophisticated approaches to the history of women and childbirth. Scholarship published in the late 1980s and 1990s made new contributions to historical understandings of the socially and culturally constructed nature of the medicalized female body. Emily Martin’s *The Woman in the Body* (1987) considered how “metaphors of production inform medical descriptions of female bodies,” contributing to a system of (overly) medicalized childbirth, the purpose of which is “efficient production and speed.”<sup>30</sup> Cynthia Eagle Russett’s *Sexual Science* (1989) argued that the scientific and medical emphasis on male/female differentiation, part of what she refers to as “scientific misogyny,” grew out of the social and cultural tensions of late nineteenth century Britain.<sup>31</sup>

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<sup>29</sup> Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell, 1984), pp. 2-5, 254.

<sup>30</sup> Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction* (Boston: Beacon Press, 1987), xxv, p. 66.

<sup>31</sup> Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood* (Cambridge: Harvard University Press, 1989), p. 206. See also Paula A. Treichler, “Feminism, Medicine and the Meaning of Childbirth,” in *Body/Politics: Women and the Discourses of Science*, eds. Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (New York: Routledge, 1990), and Jo Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking* (Cork: Cork University Press, 1998).

In the Canadian context, Wendy Mitchinson has examined the roles of both doctors and patients, deftly demonstrating the interconnectedness of gender, culture, and science. In her seminal 1991 work, *The Nature of Their Bodies*, Mitchinson argues that physicians' consistent appeals to "nature" and to the biological "reality" of women's reproductive processes mandated increasing medical surveillance of the female body, particularly during pregnancy and childbirth, and contributed to the naturalization of women's social roles.<sup>32</sup> Mitchinson's later work – most notably her 2002 monograph, *Giving Birth in Canada, 1900-1950* – focused more directly on childbirth. Furthering her argument that maternity defined the female body, she addressed why and how medical science increasingly differentiated the bodies of various women, classifying them by race, class, and age or life-stage, as well as gender. Mitchinson contends that "the normative model of a woman was one who was young enough to still be menstruating and bear children. Physicians judged young women entering puberty by how well their bodies were approaching this ideal, and they judged older women by how much their bodies had deviated from it." In addition, as she points out, physicians "differentiated between the modern and the premodern body, between the civilized and the savage body, between the young and the older body, between the middle-class and the working-class body. But at the same time, they saw women's bodies as something they could generalize."<sup>33</sup> While childbirth pain was not Mitchinson's central focus, her work, alongside noteworthy contributions from other Canadian historians,<sup>34</sup> illustrates how

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<sup>32</sup> Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991).

<sup>33</sup> Wendy Mitchinson, *Giving Birth in Canada: 1900-1950* (Toronto: University of Toronto Press, 2002), pp. 6, 304.

<sup>34</sup> Other studies focusing on how the Canadian context has shaped women's experiences in giving birth and as mothers include Comacchio's *Nations Are Built of Babies* and Katherine Arnup's

cultural and medical attitudes towards women were heavily dependent on the class-based, racialized, and place-dependent (rural or urban) perceptions of the time, and how these attitudes led to various and variable obstetrical interventions.<sup>35</sup>

Although scholarship in this subject area has highlighted how seemingly objective scientific discourses have shaped social as well as medical approaches to the pregnant female body, the history of the relationship between ideas and practices surrounding obstetric pain remains under-developed. Nonetheless, a number of important studies inform my own approach to the history of women's "birth pangs" in late nineteenth and early twentieth century English Canada. Elaine Scarry's *The Body in Pain* (1985) remains a major theoretical contribution to the wider history of pain. Here, Scarry makes important points regarding pain's (in)visibility and inexpressibility through language; the fact that pain, as Scarry puts it, "does not simply resist language but actively destroys it" partially explains why medical descriptions of women's pain in giving birth carried, and continue to carry, considerable weight for women, for society, and for medicine. Regarding the in/visibility of pain, Scarry writes that "it is not simply accurate but tautological to observe that given any two phenomenon, the one that is more visible will

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*Education for Motherhood: Advice to Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press, 1994). On the French-Canadian context, see Denyse Baillargeon, *Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910-1970* (Waterloo: Wilfrid Laurier University Press, 2007). For an analysis of First Nations women's birthing practices and white attitudes toward the Aboriginal female body, see Patricia Jasen, "Race, Colonization and Childbirth in Northern Canada," *Social History of Medicine* 10, no. 3 (1997), pp. 383-400, and Kelm, *Colonizing Bodies*. Recent work on the history of midwifery has demonstrated that the move from home to hospital was by no means universal, and that midwives continued to deliver women, especially in rural areas, well into the twentieth century. See *Reconceiving Midwifery* eds. Ivy Lynn Bourgeault, Cecelia Benoit, and Robbie Davis-Floyd (Montreal and Kingston: McGill-Queen's University Press, 2004).

<sup>35</sup> See Mitchinson, *The Nature of Their Bodies*, pp. 75-6 and *Giving Birth in Canada*, pp. 18, 160-2.



receive more attention.”<sup>36</sup> Accordingly, it can be argued that the increased visibility of labour pain prompts the medical profession and others involved in a woman’s experience of giving birth to pay more attention to its treatment. As noted, Martin Pernick demonstrated that these medical-cultural ideas about how different groups felt different levels of pain defined both how and when nineteenth century physicians used anaesthesia. Cultural perceptions of different bodies, in other words, played a major role in professional decision making.<sup>37</sup> Prevailing ideas about the varying degree of women’s “delicacy” or women’s “naturalness” translated into varying treatments and varying experiences.

More recently, scholars such as Lucy Bending have argued for the need to examine pain within its historical context, suggesting that “pain, and the ways in which it was understood and schematized, far from being abstruse,” struck at the heart of many of the debates and cultural currents of the day.<sup>38</sup> More significantly, perhaps, Bending argued that “pain was not something to be trusted and relied on, a bodily given the same for all who suffered, but instead was part of a complex and unstable system of signification, manipulable by those with power, and powerfully inflicted by such diverse categories as class, race, gender, and, in the case of the decadents of the 1890s, desire.”<sup>39</sup> Though focused on the early modern period, Katherine Walker made inroads in exploring how gender influenced historical understandings of corporeal suffering, including

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<sup>36</sup> Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (Oxford: Oxford University Press, 1985), pp. 4, 12.

<sup>37</sup> Pernick, *A Calculus of Suffering*.

<sup>38</sup> Lucy Bending, *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford: Clarendon Press, 2000), p. 3.

<sup>39</sup> Bending, *The Representation of Bodily Pain*, p. 4.

women's uniquely gendered experiences of reproductive pain, both within and outside of the birthing room.<sup>40</sup> Javier Moscoso and Keith Wailoo have further unpacked the history of pain, paying particular attention, respectively, to its cultural and political significances.<sup>41</sup> And finally, in a 2014 study that promises to become a new standard in the field, Joanna Bourke has explored "the story of pain from prayer to painkillers," arguing that by approaching pain as a "type of event" – a recurring sensation regularly experienced and witnessed by many – we can learn much about "the constitution of our sense of self and other."<sup>42</sup>

Those few studies focusing on the history of obstetric pain make important contributions to what remains an embryonic field, but also highlight the many gaps in the historiography. One of the earliest works to focus exclusively on women's pain in giving birth, Margarete Sandelowski's *Pain, Pleasure and American Childbirth: From the Twilight Sleep to the Read Method* (1984), was an inaugural contribution to the literature on women's sensitivity and pain during birth. Sandelowski asserted that physicians' promise of relief from pain and women's eager acceptance of these services constituted "arguably, the most important event in the history of American childbirth," and argued for the importance of studying the pain that "apparently defined childbirth."<sup>43</sup> Suggesting

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<sup>40</sup> Katherine Walker, "A Gendered History of Pain in England, circa 1620-1740," PhD diss., Hamilton, Ontario: McMaster University, 2011.

<sup>41</sup> Javier Moscoso, *Pain: A Cultural History* (Basingstoke: Palgrave Macmillan, 2012), and Keith Wailoo, *Pain: A Political History* (Baltimore: Johns Hopkins University Press, 2014).

<sup>42</sup> Joanna Bourke, *The Story of Pain: From Prayer to Painkillers* (Oxford: Oxford University Press, 2014), p. 5. See also Joanna Bourke, "Pain, Metaphor, Body, and Culture in Anglo-American Societies from the Eighteenth Century to the Present," *Rethinking History* (Published online 20 March 2014) and "Pain Sensitivity: An Unnatural History from 1800 to 1965," *Journal of Medical Humanities* 35, no. 3 (2014), pp. 301-319.

<sup>43</sup> Margarete Sandelowski, *Pain, Pleasure and American Childbirth: From the Twilight Sleep to the Read Method* (Westport, CT: Greenwood Press, 1984), xi, xii.

that, until 1914, the consensus among American practitioners was “that labour pain was both inevitable and necessary and therefore ought not to be relieved,” Sandelowski saw the emergence of Twilight Sleep in pre-World War I America as marking a paradigm shift in how physicians and the public perceived labour pain.<sup>44</sup> This assessment, however, raises questions about the earlier use of obstetric anaesthesia in the United States, and, as J.T.H. Connor has shown, in Canada as well.<sup>45</sup> Later historians, including Lucy Bending and Stephanie Snow, have demonstrated that this shift began in the second half of the nineteenth century and was well underway by the 1880s.<sup>46</sup> The most recent contribution to the limited historiography on pain during parturition, Jacqueline Wolf’s *Deliver Me from Pain: Anaesthesia and Birth in America* (2009), is, in many ways, much more successful. Focusing on a series of “questions” about necessity, professional respect, safety, authority, convenience, and choice that have expanded as well as deepened debates about anaesthesia in American obstetrics, Wolf’s work provides a valuable

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<sup>44</sup> Sandelowski, *Pain, Pleasure and American Childbirth*, xii.

<sup>45</sup> In his thought-provoking and rich MPhil thesis, J.T.H. Connor demonstrated that the use of anaesthetics, including in obstetrical cases, was generally accepted by the Canadian medical profession as early as the 1850s, with religious arguments against its use quickly refuted by a series of 1850 pieces in the *British American Journal of Medical and Physical Science* (BAJMPS). Though the safety of anaesthetics was increasingly called into question after the first death from chloroform in 1858, debates generally centered on how (rather than when or if) anaesthetics should be used, and the relative benefits of chloroform vs. ether. J.T.H. Connor, “To Be Rendered Unconscious of Torture: Anaesthesia in Canada, 1847-1920,” MPhil, University of Waterloo, 1983, pp. 37-39.

<sup>46</sup> Bending noted at the outset and throughout her work that the 1880s was a decade characterized by fundamental changes in the meaning of pain, while Snow suggested that after the 1880s, the view that “civilized” women were no longer capable of tolerating the pain and stress of labour sustained a marked increase in the use of anaesthesia. See Bending, *The Representation of Bodily Pain*, p. 1 and Stephanie Snow, *Operations without Pain: The Practice and Science of Anaesthesia in Victorian Britain* (New York: Palgrave MacMillan, 2005), p. 224.

exploration of the ways in which “medical and lay communities have always differentiated between labour pain and other types of pain.”<sup>47</sup>

Although Wolf frames her American study in the vital transnational context of discussions and debates taking place “among physicians about obstetric anaesthesia in the United States and Europe,” she pays no attention to Canadian developments during this period.<sup>48</sup> While not unique to her work, this explicitly limited focus is problematic. At the most basic level, this lack of acknowledgement begs the question: “what was happening in Canada?” This scholarly nearsightedness – and, at the same time, privileging of European influences over North American ones – also neglects a key issue, identified by a number of cultural historians. Culture, despite regional variations, is never entirely contained by geographic or political boundaries.<sup>49</sup> This was certainly the case for Canada, with its ties to both British and American empires. Just as important, Canadian physicians, as Mitchinson shows, kept up with the international scene and actively participated in the discussions and debates that contributed to the medical construction of female delicacy, women’s bodies, pain, and childbirth.<sup>50</sup>

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<sup>47</sup> Jacqueline Wolf, *Deliver Me From Pain: Anaesthesia and Birth in America* (Johns Hopkins University Press, 2009), p. 6.

<sup>48</sup> Wolf, *Deliver Me From Pain*, p. 23.

<sup>49</sup> As Mary Louise Adams has demonstrated in her study of the constructed nature of heterosexuality in mid-century Canada, materials produced in the United States and authored by American experts made an impact north of the 49<sup>th</sup> parallel and were often read in distinctively Canadian ways. Adams, *The Trouble with Normal*, p. 17.

<sup>50</sup> Mitchinson writes that “when the records of Canadian physicians are examined and the Canadian medical journals read, it is clear that Canadian practitioners were not isolated in a backwater or creating their own kind of medicine. They were able to keep up with the latest advances and their records abound with references to the international literature.” But, “because physicians in Canada practiced in a different social milieu from those in Britain or the United States, their efforts are worth examining...medical practice cannot be divorced from the society in which its practitioners lived.” Mitchinson, *The Nature of Their Bodies*, pp. 11-12. She makes a similar point in *Giving Birth in Canada*, reminding the reader that “to see what they [physicians]

## Methodology and Sources

Keeping in mind the internationalism of medical and cultural discourses, this study draws on material from across English Canada, but also, for contextual and comparative purposes, from Great Britain, and from the United States. This focus reflects the continual cross-fertilization of medical education, theories, and debates throughout the late nineteenth and early twentieth centuries and keeps in mind Mitchinson's important argument about the need to examine non-Canadian content, particularly that which was included in the leading texts and (Canadian) medical journals of the period. Such messages, Mitchinson argues,

are part of the context of medical practice and ignoring such content would distort the world Canadian physicians inhabited. Canadian physicians lived and practiced in Canada, but their intellectual world was not confined by national boundaries. Whether journals or textbooks, such sources reflect what Canadian practitioners were being taught and what they were reading, writing, and doing. They provide a glimpse of the wider Western perception and treatment of women as seen by practitioners in Canada.”<sup>51</sup>

At the same time, many of the physician-authors of textbooks, and, to a lesser extent, journal articles, tended to assume “that their readers either were or would be urban practitioners,” only occasionally “recognizing the specificity of rural practice.”<sup>52</sup> The majority of Canadian authors, perhaps not surprisingly, were also from Ontario. As Canada's most populated, most industrial, and most “urban” province during this period –

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were doing only with in an international context is...a rather provincial and limited view.” Mitchinson, *Giving Birth in Canada*, p. 11.

<sup>51</sup> Wendy Mitchinson, *Body Failure: Medical Views of women, 1900-1950* (Toronto: University of Toronto Press, 2013), p. 294.

<sup>52</sup> Mitchinson, *Giving Birth in Canada*, p. 15.

attributes that have led a host of historians to naturally identify it as the most “modern” of the provinces – Ontario often stands out as an interesting “case study” in this analysis, particularly as the province’s “modernity” was also seen to extend to matters of health and medicine.<sup>53</sup> Established in 1880, the Ontario Medical Association quickly became the strongest provincial chapter of the Canadian Medical Association, and the province was home to the most practicing physicians, hospitals, and, over time, medical schools.<sup>54</sup>

While this project will certainly account for the importance of place, particularly rural versus urban contexts, in shaping medical practice,<sup>55</sup> the province’s physicians and patients, as Mitchinson has pointed out, “did not exist in a cultural vacuum”: physicians’ views of the women they treated, and accordingly the treatments they offered, “were shaped by the wider culture of which they were a part.”<sup>56</sup> The culture of medical professionalism in the late nineteenth and early twentieth centuries was transnational, and to this end, cultural and professional influences from both Britain and the United States need to be accounted for. In the second half of the nineteenth century, as the young Dominion of Canada struggled to define itself and its citizenry, the Canadian medical profession remained equally embryonic. In mid-century Canada, unlike in the United

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<sup>53</sup> Cynthia Comacchio succinctly makes this point in citing these characteristics before referring to Ontario as “the most modern component of the modernizing nation.” Cynthia Comacchio, *The Dominion of Youth: Adolescence and the Making of Modern Canada, 1920 to 1950* (Waterloo: Wilfrid Laurier University Press, 2006), p. 14.

<sup>54</sup> Glenn Sawyer, *The First 100 Years: A History of the Ontario Medical Association* (Toronto: Ontario Medical Association, 1980).

<sup>55</sup> Megan Davies has argued that “region” remains a valuable analytical tool for historians of medicine, though this category of analysis is often subsumed by a focus on other factors. Megan Davies, “Mapping ‘Region’ in Canadian Medical History: The Case of British Columbia,” *Canadian Bulletin of Medical History* 17 (2000), p. 74.

<sup>56</sup> Wendy Mitchinson, “Agency, Diversity, and Constraints: Women and their Physicians, Canada, 1850-1950,” in *the Politics of Women’s Health: Exploring Agency and Autonomy*, ed. Susan Sherwin (Philadelphia: Temple University Press, 1998), p. 142.

States or Great Britain, there were relatively few places for medical training, particularly in postgraduate specialties, including, at times, obstetrics. A significant portion of licensed Canadian doctors, as a result, were foreign born and/or held foreign degrees. British credentials were often particularly respected, as evidenced by the fact that English-Canadian medical boards were quick to grant license to practice in Canada to those holding such degrees.<sup>57</sup> They were important in emergent specialties such as obstetrics and gynaecology, where many physicians travelled to London to seek out postgraduate training.<sup>58</sup>

As the year marking both the birth of Canada and of the Canadian Medical Association, 1867 is a logical starting point for this analysis. The terminal date of the study, however, was more difficult to establish. The 1920s is considered the pivotal moment in terms of Canadian “modernity.”<sup>59</sup> Historians of medicine have suggested that the same is true for hospital development and public attitudes about hospitalization, arguing that by the 1920s “Canadians from all walks of life were clamouring to be admitted to public hospitals,”<sup>60</sup> and that, at least in the American context, “the 1920s was

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<sup>57</sup> Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), p. 16.

<sup>58</sup> One of Canada’s foremost obstetricians and gynaecologists, Harold Bengé Atlee, who one scholar has identified as “a singular and representative voice in 20<sup>th</sup>-century Canadian medicine,” was typical in this regard. See Wendy Mitchinson, “H.B. Atlee on Obstetrics and Gynaecology: A Singular and Representative Voice in 20<sup>th</sup>-Century Canadian Medicine,” *Acadiensis* XXXII, no. 2 (Spring 2003), p. 4. These trends will be further explored in the first chapter.

<sup>59</sup> Cynthia Comacchio has suggested that the 1920s saw the emergence of a new and modern “generational consciousness,” particularly for adolescents, while Ian McKay has argued that the *Innocence* movement that emerged in 1920s Nova Scotia was part of a significant reaction against modernity. See Comacchio, *The Dominion of Youth* and Ian McKay, *The Quest of the Folk: Antimodernism and Cultural Selection in Twentieth-Century Nova Scotia* (Montreal and Kingston: McGill-Queen’s University Press, 1994).

<sup>60</sup> David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal and Kingston: McGill-Queen’s University Press, 2002), p. 4.

a turning point for hospital birth.”<sup>61</sup> Other historians, however, have demonstrated that the shift from home to hospital for birthing women was less drastic and less uniform. Accordingly, it makes sense to extend the study further into the interwar period, encompassing the 1930s, a decade at the end of which, for the first time, more Ontario women gave birth in the hospital than at home.<sup>62</sup> While this period witnessed a peak in terms of the medicalization of childbirth, the late 1930s and 1940s also saw the emergence of natural childbirth ideologies, particularly the teachings of British obstetrician Grantly Dick-Read, on an international level. These ideas reached new North American audiences – including Canadians – in the postwar period, and in a sense, marked the beginning of the end of the first heyday of medicalized and anaesthetized birth. As the burgeoning natural childbirth movement marked, in many ways, a simultaneously new and not so new way of conceptualizing women’s bodies and labour pain, and a new articulation of what constituted an “ideal” birth, a comment on these theories makes a fitting final chapter to this study. For these reasons, I have set 1950 as an approximate end date for this analysis, as well as a jumping off point for my continued postdoctoral research into the history of natural childbirth in English Canada.

As a study of the construction of the “delicate woman”, and particularly of physicians’ role in this process, this project tends to focus on “mainstream” medical discourse, and the bulk of materials that will be consulted were produced by physicians and other “medical professionals.” This is not to discount, however, as Kristin Burnett

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<sup>61</sup> Wolf, *Deliver Me From Pain*, p. 6.

<sup>62</sup> Jo Oppenheimer suggests that “until 1938, most births in Ontario took place at home, and after that date most births took place in the hospital.” Jo Oppenheimer, “Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century,” *Ontario History* 75 (1983), pp. 36-60.



has shown, women's informal and formal healing roles, particularly in rural areas.<sup>63</sup> Accordingly, it is important to remain cognizant of the role that women "in the middle" of expectant mothers and their physicians, particularly (and increasingly) nurses, played in shaping women's experiences in the birthing room and ideas about childbirth pain. Although women's experiences of childbirth pain have been historically and culturally situated by various actors, male physicians, for the most part, have shaped our understandings of how middle-class women experienced childbirth through their medical publications and popular advice literature. While some women did record their experiences of and feelings toward childbirth in diaries, letters, memoirs and other sources, the writings of medical professionals were (and are) more likely to be published, preserved, and subsequently accessible to historians. As Kathryn Montgomery Hunter has shown, such materials reflect physicians' privileged position in the doctor-patient relationship, and the fact that these medical narratives were figuratively inscribed on women's bodies reveals much about physician-patient power dynamics.<sup>64</sup> In a conscious attempt to continue, like much of the recent historiography, to "decentre" these medically-ordained ideas about women's pain during parturition, women's own voices are integrated into this analysis in the final two chapters.

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<sup>63</sup> Kristin Burnett, *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta, 1880-1930* (Vancouver: University of British Columbia Press, 2010). Burnett's study valuably focuses on the roles of both Aboriginal and settler women in formal and informal healing spaces/networks and is an innovative contribution to the historiography surrounding women and health care. While their contributions were important, it is important to keep in mind, as Mitchinson has argued, that "by 1900, doctors already dominated birth in Canada...for physicians, midwives were competitors, but only in a psychological sense." Mitchinson, *Giving Birth in Canada*, p. 298.

<sup>64</sup> Kathryn Montgomery Hunter has argued that medical narratives are consistently privileged over patient narratives. See Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1993).

This study offers the beginnings of a cultural history of women's "birth pangs" by examining medical attitudes towards the female body, maternity, and feminine "delicacy" or sensitivity to pain in late nineteenth and early twentieth century English Canada. The first five chapters focus, in varying ways, on the trope of "the delicate woman," exploring this construction at several sites. The final, sixth chapter offers an examination of the beginnings of an alternative view of maternity and the nature of childbirth in the post-WWII period.

Chapter 1, "'Don't Tell Them You're Guessing': Learning about Professionalism and Pregnancy in Late Nineteenth and Early Twentieth Century English Canada," begins with an examination of the state – and ongoing shortcomings – of obstetric education throughout this period. Though Canadian practitioners often knew only the basics when it came to pregnancy and birth, they drew on a core set of professional lessons, taught in Canadian medical schools, to increasingly articulate their expertise relative to their patients as well as others present in the birthing room. In showing how physicians established and continued to exert a considerable degree of control over the deliveries of their patients, well before hospital birth became the norm, this chapter provides some much needed context for the examination of the rhetoric surrounding female "delicacy" and sensitivity that follows in subsequent chapters.

Chapter 2, "'The Normal Merges into The Abnormal, The Healthy into Disease': Conceptualizing Women's Bodies and Births in Professional Medical Discourses," draws on some of the most widely-read medical reference texts and periodicals in late nineteenth and early twentieth century English Canada. Looking at these sources, which provided "the major forum for physicians in Canada to communicate with one another

and to raise issues about what concerned them,”<sup>65</sup> I offer an analysis of the medical rhetoric surrounding female “delicacy” throughout this period, focusing on the construction of varying levels of sensitivity to pain at three sites – descriptions of the female body as a whole, rhetoric surrounding the nature of pregnancy, and medical discussions surrounding the varying levels of pain women experienced in giving birth. These discourses had an undeniable impact on medical attitudes towards the provision of pain relief in the birthing room. In Chapter 3, “‘By No Means A Unanimity of Opinion’: Parturition and Pain Relief, c. 1870s-1930s,” I explore medical debates surrounding obstetric anaesthesia, unpacking arguments against and for its use, and examining physicians’ professional discussions over how best to relieve the “birth pangs” of their parturient patients. In the fourth chapter, “‘The Luxurious Daughters of Artificial Life’: Constructing ‘Delicacy’ and Pain in Popular Advice Literature,” I turn to analyzing how physicians effectively disseminated ideas about the delicate female body and the necessity for pain relief in the prescriptive works they authored for lay audiences. The fact that many women, particularly those living in rural areas, had limited access to “mainstream” medical care, especially in the prenatal period, made advice literature a particularly significant point of contact. In these volumes, medical experts articulated their views of the pathological nature of both pregnancy and parturition to construct a hierarchy of “delicate” versus “natural” bodies and births.

Chapter 5, “‘When I Think of What is Before Me, I Feel Afraid’: Popular Attitudes toward Pregnancy, Parturition, and Pain,” brings a much needed bottom-up perspective to the study. Here, I draw on selected women’s diaries and correspondence,

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<sup>65</sup> Mitchinson, *Giving Birth in Canada*, p. 16.

both published and unpublished, in order to offer a comment on how and the extent to which women appeared to internalize medical ideas about female sensitivity and susceptibility to the pain of giving birth. In a close reading of the private records they left behind, many women can be seen to be narrating their bodies and birth experiences in ways that both echoed and fuelled the prevailing medical discourses discussed in the previous chapters. Finally, Chapter 6, “A New Way to Birth? Grantly Dick-Read and the Burgeoning Natural Birth Movement in Postwar Canada,” highlights the growing popularity of natural childbirth ideologies, as expressed in Dick-Read’s *Childbirth Without Fear* (1944), and questions whether these represented a significant shift in the ways in which pregnancy and birth were perceived by expectant Canadian parents.

Given the current quantitative studies that demonstrate how women perceive themselves to be the more sensitive sex, and the resultant questions about the relationship between gender and pain, historical research into these topics is particularly timely. Medical and cultural emphases on female sensitivity to bodily pain have, and continue to, both privilege and disadvantage women. Such discourses open the way for further scientific research, more effective diagnosis and intervention, as well as greater medical attention and access to pain relief for the women in question. But they also contribute to the increasing medicalization of childbirth, and fundamentally, of the female body. As the advocates of “natural” versus “modern” medicalized childbirth seem to be increasingly at odds, and as rates of epidural anaesthesia and caesarean delivery continue

to increase, these remain questions of vital importance to women's health and health care delivery.<sup>66</sup>

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<sup>66</sup> Physicians have increasingly spoken out about the dangers associated with both epidural anaesthesia and C-sections. See, for example, Cathy Gulli, "As rate of C-sections rises, so do known risks," *Macleans* 8 January 2009, and Kate Fillion, "Women don't have to push so much: Dr. Aaron Caughey on labour and how epidurals changed childbirth," *Macleans* 26 September 2011. In 2010, the World Health Organization set a 20% rate of caesarean section as the threshold for defining "overuse" of the procedure. Canada's caesarean section rate was noted to be 26.3%.

## Chapter 1

### “Don’t Tell Them You’re Guessing”:

#### Learning about Professionalism and Pregnancy in Late Nineteenth and Early Twentieth Century Canada

After receiving his M.D. from the University of Toronto in 1908, Abraham Isaac Willinsky accepted a position as a *locum tenens* in Carp, Ontario, a rural community outside of Ottawa. Arriving to take over the practice of Dr. Magee, a graduate of McGill, which consistently rivalled Toronto in terms of Canada’s ‘best’ medical school during this period,<sup>1</sup> Willinsky was quickly asked, “What do you know about babies?” His response – “Well, I can recognize them” – reflected his self-confessed “greenhorn” status when it came to obstetrics. The senior doctor gave the novice his best advice when it came to obstetric cases: “If you run across something you don’t recognize, never let on. Don’t tell them you’re guessing. Instil [sic] confidence – that’s the main thing.”<sup>2</sup>

The first section of this chapter takes the accounts of Canadian medical students and new practitioners as a starting point to examine the state of medical education in

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<sup>1</sup> Millar, Heap, and Gidney write that by 1910, the University of Toronto “had long prided itself on being *the* provincial university, standing first in Ontario. Increasingly through the first half of the century, it also aspired to stand first among universities in all of Canada (contesting that honour with McGill) and to claim a place among the best universities in the whole of North America.” Wyn Millar, Ruby Heap, Bob Gidney “Degrees of Difference: The Students in Three Professional Schools at the University of Toronto 1910 to the 1950s,” in *Learning to Practice: Professional Education in Historical and Contemporary Perspective* (Ottawa: University of Ottawa Press, 2005), pp. 155-6. McGill also had an international reputation for excellence. Willinsky for example, suggested that McGill “was far in the lead in my day...when I went to Vienna for post-graduate work...the doctors there knew of only one Canadian University: McGill.” A.I. Willinsky, *A Doctor’s Memoirs* (Toronto: The MacMillan Company of Canada, Ltd., 1960), p. 24. Growing up in Southwestern Ontario, Archibald D. Campbell also recalled his father making the same point in the first decades of the twentieth century. *Autobiography*, Archibald Daniel Campbell Fonds, P 174, Osler Library for the History of Medicine, p. A79.

<sup>2</sup> Willinsky, *A Doctor’s Memoirs*, pp. 28-30.

obstetrics at Canadian medical schools at the turn of the twentieth century. Though many of the most popular medical textbooks of the period, written by a mix of Canadian, American, and British authors, stressed the need for specialists and general practitioners alike to be proficient in obstetrics, students at a variety of Canadian schools routinely expressed the belief that they were instead expected to “bluff it out” when it came to attending confinements.<sup>3</sup> While medical schools routinely stipulated that students had to attend a set number of deliveries to pass courses in obstetrics, student narratives call into question how strictly these requirements were enforced. When the 1910 Flexner *Report on Medical Education in the United States and Canada* decreed that for several Canadian schools “the very worst showing [was] in the matter of obstetrics,” professional outcry over the “crisis” in obstetrical training quickly escalated.<sup>4</sup> Although schools were quick to rebut the claims made in the report, while simultaneously putting new requirements into place in the post-Flexner years, student comments compel us to call into question the quality and amount of obstetrical training students received, well into the interwar period.

The second half of the chapter will turn to exploring the gendered and professional messages new Canadian practitioners received throughout this transformative period. In their often limited education, Canadian medical students received important lessons in professional conduct that allowed them to articulate and emphasize their professional expertise relative to their expectant female patients. As the majority of licensed physicians in late nineteenth and early twentieth century Canada

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<sup>3</sup> This was the advice Willinsky received from Magee, though he ultimately concluded that while “the ‘bluff it out’ approach might work for a business man...disease knew all too well how to call a bluff.” Willinsky, *A Doctor's Memoirs*, pp. 28, 33.

<sup>4</sup> Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (1910), p. 117.

were male,<sup>5</sup> the gendered power dynamics of this relationship need to be unpacked. At the same time, medical texts included consistent instructions on how new practitioners, as licensed physicians, could distance themselves from other “less qualified” medical personnel, including, most notably, midwives and nurses. These professional dynamics provided the broader context for medical constructions of the “delicate woman”, a trope that was central to conceptualizations of maternity, medicalized birth, and labour pain throughout the late nineteenth and early twentieth centuries.

Though physicians did not always agree on the dominant interpretations of the nature of the female body, pregnancy, childbirth, and anaesthetization – as will be further discussed in Chapters 2 and 3 – there was a growing emphasis on the mainstream medical practitioner’s role as the only qualified interpreter of the sights, sounds, and sensations of the birthing room. The ongoing limits of obstetrical training, coupled with renewed emphasis on the physician’s position of authority and expertise in the birthing room, ensured that professional medical discourses, including reference texts, periodicals, and prescriptive or advice literature, played an ongoing role in shaping the ways in which Canadians perceived pregnancy, pain, and parturition, well into the interwar period.

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<sup>5</sup> Historians R.D. Gidney and W.P.J. Millar suggest that at the University of Toronto in the first decades of the twentieth century, roughly 10% of students were female. R.D. Gidney and W.P.J. Millar, “Medical Students at the University of Toronto, 1910-1940: A Profile,” *Canadian Bulletin of Medical History* 13 (1996), p. 37. The most popular medical texts of the period also consistently gendered medical students as male, aiming to offer assistance to the student “in mastering *his* class and *his* clinical work.” R.W. Garrett, *Text Book of Medical and Surgical Gynaecology: For the Use of Students and Practitioners*, Second Revised Edition (Kingston: R. Uglow & Co., 1910), Preface to the Second Edition. Cheryl Krasnick Warsh states that in 1911, 2.79% of Canadian doctors were women. By 1921, this figure had dropped to 1.8%. In 1941, 3.7% of Canadian physicians were female. Cheryl Krasnick Warsh, *Prescribed Norms: Women and Health in Canada and the United States since 1800* (Toronto: University of Toronto Press, 2010), pp. 201.



## ‘The very worst showing’: Obstetric Education in Turn-of-the-20<sup>th</sup> Century Canada

By the late-Victorian period, mainstream medical practitioners routinely recognized that obstetrics was, in many ways, the backbone of general practice and a key way for doctors to secure patients for life.<sup>6</sup> Nevertheless, the subject had a limited place in Canadian medical school curricula until well into the twentieth century. While the most popular medical textbooks of the period stressed the need for specialists and general practitioners alike to be proficient in obstetrics, medical school calendars and student accounts suggest a different picture. Although the quality of instruction understandably varied, the ambiguities and uncertainties that surrounded obstetrical training did much to shape broader perceptions of pregnancy throughout this transformative period.

The roots of what historian Wendy Mitchinson has referred to as the “uncertain world of obstetrics” in early twentieth century Canada can be traced back to the mid-Victorian period.<sup>7</sup> British North America’s first medical education program was established in 1824 at the Montreal Medical Institution, and was formally recognized by McGill University five years later. The University of Toronto (the U of T) originally

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<sup>6</sup> A 1874 article in the *Canada Lancet* included the suggestion that “it has long been noted that success in midwifery paves the way for family practice, and serves indeed as the best foundation for the practitioner’s success in life.” “The Cultivation of Obstetrics,” *Canada Lancet (CL)* 7, no. 2 (October 1874), p. 58. University of Toronto Professor of Obstetrics Dr. Adam Wright wrote in his 1908 text, originally published in 1905, that “the gratitude of obstetrical patients forms the best sort of capital for medical practitioners.” Adam H. Wright, *A Text-Book of Obstetrics* (New York and London: D. Appleton and Company, 1908), p. 85. Barton Cooke Hirst, the author of one of the leading obstetrical texts of the day, asserted that “every physician is popularly supposed to be able to manage a labor, and such cases are among the first that he is called upon to attend.” Barton Cooke Hirst, *A Text-Book of Obstetrics* (Philadelphia and London: W.B. Saunders Company, 1912), p. 170. Likewise, William Victor Johnston, who received his MD from the University of Toronto in 1923 commented that “childbirth is one of the most common conditions the family doctor is called upon to treat, and one of the most fascinating – offering the most tangible rewards.” William Victor Johnston, *Before the Age of Miracles: Memoirs of A Country Doctor* (New York: Paul S. Eriksson, Inc., 1972), p. 43.

<sup>7</sup> Mitchinson, *Giving Birth in Canada*, pp. 47-68.

opened its medical school at King's College in 1843, but suspended formal classes after a decade, transferring teaching duties to a selection of proprietary schools – Trinity Medical College, the Toronto School of Medicine, Victoria University (also known as Rolph's School), and Woman's Medical College. Medical teaching at the U of T resumed in 1887. By 1900, medical faculties existed at the University of Montreal (1843), Laval University (1848), Queen's University (1854), Dalhousie University (1867), the University of Western Ontario (1881), and the University of Manitoba (1883).<sup>8</sup> Individual requirements for admission varied widely, but no program required students to have a previous undergraduate degree.<sup>9</sup> As a result, students tended to be quite young, a characteristic that had bearing on school curricula and contributed to the ongoing place of liberal arts education, particularly in the first year of medical studies.<sup>10</sup>

At most medical schools, the student body also tended to be quite homogenous, composed largely of the white, Anglo-Saxon, Protestant sons of the growing middle-class, with the sons of professionals and businessmen making up the largest groups.<sup>11</sup> Minority students often faced particular discrimination. Willinsky, whose account opened this paper, recalled several barriers he encountered as a Jewish student at the University

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<sup>8</sup> See N. Tait McPhedran, *Canadian Medical Schools: Two Centuries of Medical History, 1822 to 1992* (Montreal: Harvest House, 1993).

<sup>9</sup> The University of Toronto, one of the more prestigious schools, had a minimum matriculation requirement. As late as 1910, about 90 percent of students entered with no more than a high school education. Gidney and Millar, "Medical Students at the University of Toronto," p. 32.

<sup>10</sup> Medical students at the U of T had an average age of 20 in 1910 and 19 in 1930. This age "affected everything from increased regulation over dissecting-room rule or classroom behaviour, to the structure of the program itself..." Gidney and Millar, "Medical Students at the University of Toronto", pp. 33-34.

<sup>11</sup> Gidney and Millar recall that at the University of Toronto, medical students were also more likely to come from urban rather than rural Ontario. "They were also overwhelmingly white, Protestant, and of British stock." Gidney and Millar, "Medical Students at the University of Toronto," p. 37.

of Toronto in the early 1900s, including difficulties working with certain professors, and in securing internship opportunities.<sup>12</sup> Historian Jackie Duffin has recently suggested that the ongoing existence of quotas and discriminatory admission practices shaped both the makeup of medical school student bodies and individual student experiences until well into the twentieth century.<sup>13</sup>

Reflecting, and perhaps reinforcing the gender and racial homogeneity of Canadian medical school classes, the majority of Professors were also white men, hailing predominantly from Anglo-Saxon, Protestant backgrounds and the middle classes. Howard J. Alexander, who received his M.D. in 1925, stated that at his alma mater, the University of Toronto, “all the professors were either English, Irish, or Scottish,” and appeared to favour students from these backgrounds. Alexander recalled:

First surgical clinic, down at St. Michael’s Hospital, the clinician was Dr. Malcom Hector Valentine Cameron, very Scottish. He looked over the list of names, there were ten of us in the group, and he said, “I see just two good Scottish names here – Alexander and Ross.” We happened to have a student in our group, his real name was Rosen, but he had changed it to Ross; so he put up his hand and Dr. Cameron looked at him and never said a word...<sup>14</sup>

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<sup>12</sup> Willinsky recounted “it was bitter to find that... all doors were closed to me when I graduated.” Recalling his relationship with Prof. Alexander McPhedran, Willinsky remembered, “I felt that he did not like either my name or my people, that because I was a Jew I would never be given a chance to prove myself as a student of medicine in his eyes. Such an attitude was common enough on campus then.” Willinsky, *A Doctor’s Memoirs*, pp. 23-24. Despite these experiences, Gidney and Millar describe the rising number of Jewish students at the U of T as “a note of grace in an otherwise hostile environment.” Gidney and Millar, “Medical Students at the University of Toronto,” p. 40.

<sup>13</sup> Jacalyn Duffin, “The Queen’s Jews: Religion, Race, and Change in 20<sup>th</sup> Century Canada,” *Canadian Journal of History* 49, (Winter 2014), pp. 369-394.

<sup>14</sup> Howard J. Alexander, *56 Years in Medical Practice*. Compiled and Edited by Frank Fubie (Tillsonburg: Bennett Stationary, Ltd., 1981), p. 14. Willinsky also suggested that “the Scots were

By the first decades of the twentieth century, at Canada's most prestigious institutions – the University of Toronto and McGill – the four year medical curriculum was divided into two fairly equal sections, with the first two years “devoted mainly to laboratory sciences....and the last two to clinical work in medicine, surgery, and obstetrics.”<sup>15</sup> When it came to learning obstetrics, the quality of instruction understandably varied from institution to institution, professor to professor, and even student to student.<sup>16</sup> Though William Victor Johnston (1897-1976) recalled that during his time as a medical student at the University of Toronto in the early 1920s there were “teachers for whom we all had the utmost respect,” he also expressed his belief that “other lecturers, in considerable number, were satisfied just to fill our minds with facts we could have gotten from books.” The prevailing attitude of many professors, he suggested, seemed to be: “listen to what I have to tell you and be prepared to give it back without argument at examination time.” At the same time, instructors were often willing to let some things slide for certain students. Johnston recalled, for example, hearing one of his professors comment to a colleague, “that Johnston boy doesn't know very much, but he is going to [work in] the north country, so I think I'll pass him.”<sup>17</sup>

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certainly to the fore” at Toronto General Hospital as well, contributing to an ongoing “conservative climate” at the hospital. Willinsky, *A Doctor's Memoirs*, p. 86.

<sup>15</sup> Flexner, *Medical Education in the United States and Canada*, p. 117.

<sup>16</sup> Martin Pernick has suggested that regional differences also played a significant role in nineteenth century American medical education, particularly when it came to teaching students about anaesthetization and the use of chloroform versus ether. Individual medical schools had different opinions, with “geography profoundly influenc[ing] patterns of communication and personal influence within antebellum American medicine.” Pernick, *A Calculus of Suffering*, p. 207.

<sup>17</sup> In this environment, Johnston recalled that it was very easy for most students “to hang back and do nothing but listen” during periods of clinical instruction. Johnston, *Before the Age of Miracles*, pp. 15, 17.

Throughout the late-Victorian period, the place of obstetrics in Canadian medical schools was a source of ongoing discussion, and for many, of concern. Though the state of obstetric education had come a long way from the early nineteenth century, when, as Mitchinson has argued “the formal education of physicians was a confusing choice between apprenticeship (whatever this meant) and formal education, divided as it was among various competing proprietary schools and public institutions” both within and outside of Canada, anxieties surrounding the need for greater training persisted.<sup>18</sup> The fact that foreign credentials, particularly in postgraduate specialties in obstetrics, appear to have been commonplace well into the twentieth century is indicative of these ongoing anxieties.

International educational experiences gave new Canadian practitioners the opportunities to work with some of the leading names in medicine, particularly when it came to training in midwifery and obstetrics.<sup>19</sup> Kenneth Neander Fenwick, who earned his M.D. from the Royal College of Physicians and Surgeons in Kingston, Ontario in 1871, and went on to become Professor of Obstetrics and Diseases of Women and Children at Queen’s University in the late nineteenth century, undertook postgraduate training at St. Thomas’ Hospital in London.<sup>20</sup> Willinsky recalled travelling to Europe in Fall 1909 to undertake a six month postgraduate course at the Rotunda Hospital in Dublin, working towards a Licentiate in Midwifery, based on the advice of a fellow doctor

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<sup>18</sup> Mitchinson, *The Nature of Their Bodies*, p. 24.

<sup>19</sup> Willinsky described a sense of excitement at the possibility of going to work “among the old universities and the famous hospitals” with “many men whose books I had studied.” Willinsky, *A Doctor’s Memoirs*, p. 35.

<sup>20</sup> Kenneth Neander Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics* (Kingston: John Henderson & Co., 1889). Fenwick also travelled to New York for additional training.

who told him, “If you’re interested in babies, Dublin’s the place” and assured him that the L.M. degree “meant something,” perhaps suggesting the opposite for Canadian credentials.<sup>21</sup> At the Rotunda, he encountered other Canadian practitioners, and was quickly paired with a roommate who had come to study the L.M. after a period of teaching midwifery at McGill. Though his roommate “was like a boy let out of school” while in Dublin, making good use of the Guinness provided to Rotunda students in a dedicated common room and, as a result, missing “many of his calls,” Willinsky was more than willing to take on extra cases for additional experience. By the end of the course, he recalled that he had attended “almost four times the number of deliveries required for the degree.”<sup>22</sup> Other practitioners described similar international experiences.

Reflecting the fact that, as Willinsky noted, “the British schools predominated the background of most of the University men” in Canada, young physicians travelled to medical centres including London and Edinburgh to undertake additional study in a variety of subjects.<sup>23</sup> Study in continental Europe, in cities like Paris and Vienna, was also a popular option.<sup>24</sup> So too was additional training in the United States. Dr. Wilfred

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<sup>21</sup> Willinsky, *A Doctor's Memoirs*, p. 35.

<sup>22</sup> Willinsky, *A Doctor's Memoirs*, pp. 36-37.

<sup>23</sup> Willinsky, *A Doctor's Memoirs*, p. 81. Howard J. Alexander undertook postgraduate lectures in surgery in London. Alexander, *56 Years in Medical Practice*, p. 14. See also Samuel S. Peikoff, *Yesterday's Doctor: An Autobiography* (Winnipeg: The Prairie Publishing Company, 1980). Peikoff, who would receive his M.D. from the University of Alberta in the mid-1920s, went to Edinburgh. Professor John Clarence Webster, who trained in Edinburgh and taught in the Department of Midwifery and Diseases of Women at the University there before being appointed Lecturer in Gynaecology at McGill in 1896 provides one such example of a British-trained Canadian professor. John Clarence Webster Fonds, P 011, Osler Library for the History of Medicine.

<sup>24</sup> Undertaking general training in Vienna after leaving Dublin, Willinsky encountered two of his Toronto colleagues doing the same. Willinsky, *A Doctor's Memoirs*, pp. 24, 41-42, 105. Ontario-born Jack Elmer Harrison, who graduated with an M.D. from McGill in 1923, also undertook postgraduate training in Vienna, before going on to work as a senior obstetrician at Vancouver

Abram Bigelow, who had received his M.D. from Toronto in 1903, recalled getting in the habit of biannual American visits to “large surgical centres” in the first decades of the twentieth century. He later remarked that he knew this was “more travelling than most of my Canadian associates managed at the time.” His sense of unease about his own Canadian credentials may have fuelled his ongoing assessment of Toronto as a “stuffy and provincial medical school” lacking the research-driven focus and prestige of other institutions, a view that led him, even in the post-World War II period, to advise his son “don’t stay there after you graduate – go to the Mayo Clinic.”<sup>25</sup> When practitioners returned home, they often made a point of publicizing and promoting what they had learned abroad. Such was the case with Montreal physician A. Lapthorn Smith who, upon his return from a summer studying gynaecology in Europe, placed an announcement in a September 1898 edition of *The Canadian Medical Review (TCMR)*, announcing his intent to form a post-graduate class for a small group of practitioners, where, “following the example of European gynaecologists,” he would offer a “course of demonstrations lasting one month.”<sup>26</sup>

While the place of obstetrics in Canadian (and American) medical school curricula was limited, there is some evidence of change over the course of the late nineteenth and early twentieth centuries. Jacqueline Wolf argues that throughout the nineteenth century, the majority of American physicians “considered obstetrics a trivial

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General Hospital and Associate Professor in Obstetrics and Gynaecology at the University of British Columbia. Jack Elmer Harrison Fonds, P 173, Osler Library for the History of Medicine.

<sup>25</sup> Wilfred Abram Bigelow, *Forceps, Fin & Feather: The Memoirs of Dr. W.A. Bigelow* (Altona, MB: Frieson & Sons, 1970), xvii, pp. 34, 41.

<sup>26</sup> *The Canadian Medical Review* 8, no. 3 (September 1898), p. 73.

sideline, unworthy of professional training, attention, and respect.”<sup>27</sup> The emerging specialty was seen by many North American doctors as less prestigious than surgery and other research-based branches of medicine, but as the professionalization of obstetrics continued in the second half of the nineteenth century, the subject enjoyed increasing prestige and presence at Canadian medical schools. Students at McGill and Queen’s University were required to take “two full courses of six months each” in Obstetrics and the Diseases of Women and Children from the 1850s and 1860s onwards.<sup>28</sup> Until the early 1870s, McGill calendar listings for courses on midwifery specified instruction based on “a series of drawings on a large scale; by humid preparations<sup>29</sup>; by models in wax; and by use of the artificial pelvis” or obstetric phantom or manikin (see Figure 1.1). In the 1872-1873 academic year, this description was amended to include clinical “cases in the wards of the Lying-in Hospital” as an additional means of instruction.<sup>30</sup> Midwifery lectures in the senior years were one hour long, interspersed with instruction in gynaecology on alternate days. Perhaps as a recognition of the shortcomings of

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<sup>27</sup> Wolf, *Deliver Me From Pain*, p. 20.

<sup>28</sup> McGill University, 1852-1853 Academic Calendar, p. 8. Queen’s University and College, Kingston, Faculty of Medicine Calendar, 1865-1866.

<sup>29</sup> Over the course of the nineteenth century, “humid” or “wet” preparations of anatomical specimens were increasingly preferred over their “dry” counterparts, as they offered a better preservation of the colour, texture, and natural shape of body parts including the uterus. For more information, see Samuel J.M.M. Alberti, “Anatomical Craft: A History of Medical Museum Practice,” in *The Fate of Anatomical Collections*, eds. Rina Knoeff and Robert Zwijnenberg (Burlington, VT: Ashgate, 2015), pp. 231-246.

<sup>30</sup> McGill University Calendars, 1868-1869, 1872-1873, p. 10. After completing one course of lectures in Midwifery, students were able to attend cases at the University Lying-In Hospital, but were advised to do so “as much as possible during the Summer, when there are as many patients and not so many pupils as in the winter, a larger proportion of cases falls to the share of each.” McGill University Calendar, 1872-1873, p. 12.



**Figure 1.1**



Obstetric Phantoms, Italian, c. Eighteenth Century. Wellcome Library, Reference no. Science Museum A60052. Images reproduced with permission under Creative Commons license from Wellcome Images.

instruction during the academic year, summer course offerings, available at the additional cost of \$10 per class, often focused on obstetrics.<sup>31</sup>

Despite the growing emphasis on clinical instruction, obstetric operations continued to be demonstrated “with the phantom and preserved foetus.”<sup>32</sup> McGill introduced the bronze mechanical pelvis as a teaching tool in the late 1880s, and by the end of the decade, a growing number of practical classes on midwifery, combining

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<sup>31</sup> McGill University Calendar, 1879-1880, p. 33. To enroll in these “not mandatory, but recommended” offerings, students paid an additional fee of \$10 per class by the mid-1880s. McGill University Calendar, 1884-1885.

<sup>32</sup> McGill University Calendar, 1884-1885, p. 34

instruction on cadavers, phantoms, and clinical cases, appear to have been introduced.<sup>33</sup> In 1890, the University announced the purchase of “an improved Tarnier-Budin [obstetric] phantom,” providing students with “every facility” necessary for “acquiring a practical knowledge of the various obstetric manipulations.”<sup>34</sup> Introducing arrangements for a new course of individual clinical instruction at Montreal Maternity Hospital in the same year, the university also explicitly restated what appears to have been a long-standing requirement – that before a practitioner could receive a degree, “he must also give proof by ticket...of having attended at least six cases of labour.”<sup>35</sup> These requirements, McGill students were reminded, were by no means as strict as the number of cases required to qualify for license in Great Britain.<sup>36</sup>

At the University of Toronto, clinical teaching, recognized in 1892 as “perhaps the most important element in medical education,” was also increasingly emphasized in the curriculum over the second half of the nineteenth century, though other more traditional teaching methods persisted.<sup>37</sup> The 1889 U of T Medical Faculty Calendar had expressed that “lectures and demonstrations in the final subjects,” including obstetrics,

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<sup>33</sup> McGill University Calendar, 1887-1888, pp. 33, 57-58.

<sup>34</sup> McGill University Calendar, 1890-1891, p. 48.

<sup>35</sup> McGill University Calendar, 1890-1891, p. 38.

<sup>36</sup> McGill University Calendar, 1889-1890, p. 49. By the first decade of the twentieth century, though requirements varied from institution to institution, Canadian physicians recognized that students in Great Britain were expected to demonstrate “personal attendance on about fifty cases each.” Though many American universities boasted that their average graduates had attended more than the requirement, leading American practitioners argued, like their Canadian counterparts, for a six case minimum. “The Present Status of Obstetrical Education in Europe and America,” *Western Canadian Medical Journal (WCMJ)* 4, no. 6 (June 1910), pp. 262, 274.

<sup>37</sup> *University of Toronto Report of the Standing Committee of the Faculty of Medicine on the Subject of Hospital Facilities* (Toronto: Rowsell & Hutchinson, University Printers, 1892), pp. 3-4. These more traditional methods included “lectures and recitations...illustrated by diagrams and operations on the phantom.” University of Toronto, Medical Faculty Calendar, Session 1889-1890, p. 21.

would be “as far as possible, practical in character.” Courses in obstetrics, taught by Professor Adam H. Wright, one of the leading researchers in the field at the turn of the twentieth century, were described as focusing on “lectures and recitations on the Science and Art of Obstetrics....illustrated by diagrams and operations on the phantom,” with “special attention...paid to the emergencies of obstetric practice.” Senior students undertook “a systematic course in bedside instruction” at the affiliated Burnside Lying-In Hospital, and were also permitted “to make engagements with out-patients and attend them in confinements in their own homes.”<sup>38</sup> Into the first decades of the twentieth century, all U of T medical students were required to “conduct” at least six labours by their fourth year examinations, and were required to provide a certificate (see Figure 1.2) as proof that they had completed this requirement.<sup>39</sup> By 1900, the University announced “greatly improved” facilities for clinical instruction, and though “practical demonstrations” continued to take place on the obstetric phantom, cadavers were increasingly used as an additional means of instruction.<sup>40</sup> These guidelines, more or less, continued at U of T throughout the first decade of the twentieth century, until approximately 1913, when an additional year of clinical instruction in obstetrics was added.<sup>41</sup>

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<sup>38</sup> University of Toronto, Medical Faculty Calendar, Session 1889-1890, pp. 18, 21, 39-40. Willinsky also made note of this provision. Willinsky, *A Doctor's Memoirs*, p. 64.

<sup>39</sup> On some instances, the verb “attend” was used in the place of “conduct”. See University of Toronto, Medical Faculty Calendar, Session 1889-1890, p. 51; Session 1915-1916, p. 39;

<sup>40</sup> University of Toronto, Medical Faculty Calendar, Session 1899-1900, pp. 6, 27-28.

<sup>41</sup> In 1924, this five-year curriculum was proclaimed “a thing of the past,” as U of T introduced a new requirement for six years’ of study for the medical degree. “Want Fewer Students Says Dean of Medicine,” *Canadian Journal of Medicine and Surgery (CJMS)* 54, no. 2 (February 1925), p. 67.

Figure 1.2



Ticket admitting Mr. J.M. Park to six cases of labour at the Burnside Lying In Department of the Toronto General Hospital during the 1902 academic session at the University of Toronto Medical School. James C. Goodwin Collection, MU 7543, Image reproduced with permission from the Archives of Ontario.

While, at least on paper, the place of obstetrics in Canadian medical schools appears to have increased during these decades, student narratives and external assessments suggest an ongoing disconnect between statements about the significance of the specialty and the extent to which students graduated with an ability to proficiently

manage births. In the late nineteenth century, it is likely that these feelings extended to other medical specialties as well. Abraham Groves, who received his M.D. from the Toronto School of Medicine in 1871 and went on to practice surgery in Fergus, Ontario, recalled that “during my undergraduate course there was not, so far as I know, one abdomen opened in the Toronto General Hospital.” As late as 1874, he recounted that he “had never seen the abdomen of a living person opened,” a fact that led him, understandably, to approach his first ovariectomy with some caution, though he ultimately concluded that “I was thrown wholly on my own resources, which is not, after all, a bad thing for a young man.”<sup>42</sup>

Practitioners do, however, appear to have singled out obstetrics as a field requiring further instruction. Though Professors like Adam Wright emphasized the expectation that it would take “an educated woman or man not less than four years to learn how to properly conduct a normal case of labour,” perceived deficits in student training were an ongoing source of anxiety.<sup>43</sup> Personal narratives also call into question how strictly existing curriculum requirements were enforced. Though students were required to provide documentation of the deliveries they attended to fulfill the “six case requirement,” Willinsky, whose account opened this chapter, for example, also recalled the popular attitude amongst students at the U of T in the early 1900s: “as we used to say, ‘it counted if you got there in time to hear the first cry.’”<sup>44</sup>

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<sup>42</sup> Abraham Groves, *All in the Day's Work: Leaves from a Doctor's Casebook* (Toronto: The MacMillan Company of Canada, Ltd., 1934), pp. 3, 15.

<sup>43</sup> Wright, *A Text-Book of Obstetrics*, p. 85.

<sup>44</sup> Willinsky, *A Doctor's Memoirs*, pp. 20-21.

While calls to reform the Canadian medical school system already had a long history,<sup>45</sup> these criticisms found a widespread and captive audience with the publication of the Carnegie Foundation Report on *Medical Education in the United States and Canada* in 1910. This document, which quickly became known as the Flexner Report after its author, American education critic Abraham Flexner (1866-1959), directed the harshest criticisms at schools in the United States, commenting that the state of medical education north of the border “had never become so badly demoralized.”<sup>46</sup> For Canadian practitioners, the sense of competition between Canadian and American schools appears to have been building in the years immediately preceding the publication of the report. A 1908 editorial published in the *Canadian Journal of Medicine and Surgery (CJMS)* posed the question “Can Canada afford to be behind the United States?” and argued for the need to raise the standard of matriculation required for Canadian programs to match developments south of the border. Higher standards were framed as a necessity of the utmost importance: “If the twentieth century is to see Canada dazzle the world in growth of population, in progress, and in prosperity, the medical profession cannot afford to stand still.”<sup>47</sup> Commenting on the state of medical education, Flexner praised the trend at some Canadian schools to extend undergraduate programs to five years, and recognized McGill and Toronto graduates as possessing the ideal “self-supporting” temperaments for rural practice. Nevertheless, the report placed the two leading Canadian universities in the

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<sup>45</sup> At his 1865 installation as a Professor in the Faculty of Medicine at Queen’s University, Donald MacLean remarked that “there is the most imperative demand for reform in medical education in the Canadian schools.” Donald MacLean, *On The Medical Profession and Medical Education in Canada: Address Delivered at His Installation as Professor of the Institutes of Medicine, Queen’s University, January 10, 1865*, p. 11

<sup>46</sup> *Medical Education in the United States and Canada*, p. 326.

<sup>47</sup> “Medicine Demands a Higher Preliminary Education,” *CJMS* 24, no. 2 (August 1908), p. 79.

second division of medical schools, below the leading American institutions that had higher entrance requirements.<sup>48</sup> Singling out the University of Western Ontario (now Western University), Flexner decreed that for Canadian schools, “the very worst showing [was] in the matter of obstetrics.”<sup>49</sup>

Holding up clinical training above all other forms of instruction, Flexner questioned the value of lectures and existing teaching methods, including the obstetric phantom or manikin, which he described as “of value only to a limited degree.”<sup>50</sup> Rather than watching, listening, and memorizing, Flexner asserted that the medical student’s “own activities in the laboratory and the clinic [were] the main factors of his instruction and discipline.”<sup>51</sup> Accordingly, out-patient work was framed as a particularly important part of the development of young physicians. Lamenting that the student trained fully in the field through solo out-patient work “gets about the same training as a midwife” and asserting that students should always be accompanied by a trained doctor, Flexner drew a clear and hierarchical distinction between physician and non-physician care.<sup>52</sup>

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<sup>48</sup> *Medical Education in the United States and Canada*, pp. 15, 24. The first division of schools required two or more years of college work for entrance; the second demanded graduation from a four-year high school or its equivalent; while the third “ask little or nothing more than the rudiments or the reconciliation of a common school education.” *Medical Education in the United States and Canada*, p. 28.

<sup>49</sup> *Medical Education in the United States and Canada*, p. 117.

<sup>50</sup> *Medical Education in the United States and Canada*, p. 117. Canadian practitioners and medical educators appear to have shared these criticisms. Queen’s University Professor of Obstetrics and Gynaecology, R.W. Garrett, for example, wrote in his 1910 text that “lectures, to be interesting, instructive, and impressive, should assume more the form of demonstrations, than set lectures, during which important features might be made plain, knotty questions discussed, obscure points elucidated, and methods for treatment made clear by the aid of blackboard drawings, maps, plates, and morbid specimens, leaving the intervening material for study elsewhere.” Garrett, *Text Book of Medical and Surgical Gynaecology*, Preface to First Edition (1897).

<sup>51</sup> *Medical Education in the United States and Canada*, p. 53.

<sup>52</sup> *Medical Education in the United States and Canada*, p. 118.

Canadian physicians were quick to respond to the Report in the first edition of the *Canadian Medical Association Journal (CMAJ)* published in 1911. Pledging to forge a reciprocal teaching relationship, Canada's two leading medical schools – the U of T and McGill – expressed the aim to join forces in the “desire to pursue a higher ideal in medical education.”<sup>53</sup> Other Canadian schools, subjected to harsher criticisms, were less positive in their responses. Halifax Medical College called the reformers “over zealous” and took particular issue with the charge that their dissecting room was “ill-smelling.”<sup>54</sup> Faculty at Queen's University criticized Flexner and his colleagues for conducting a “superficial and rapid” inspection, and found the report riddled with “frequent inaccuracies,” particularly with regards to the description of Queen's so-called “limited” clinical facilities and obstetrical cases. They responded publicly to Flexner: “The faculty notes that the report does not show that there is any school where obstetrical cases are considered sufficient in number, and claims that Queen's students have as many as those of other schools...Although piqued, the faculty believes that it is justified, in view of the hurried inspection, in not taking the report very seriously.”<sup>55</sup>

Despite attempts to “brush off” some of the criticisms contained in the Report, medical education underwent significant reform in the post-Flexner years. After 1910, Jackie Duffin argues, Canadian schools were “intent in emphasizing the high quality of their education, the rich opportunities for scientific and clinical learning, and increasingly

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<sup>53</sup> “Reciprocity in Teaching,” *Canadian Medical Association Journal (CMAJ)* 1, no. 1 (January 1911), pp. 60-61.

<sup>54</sup> Describing their “well-ventilated” dissection room, Halifax Medical College remarked “we have not heard that a dissecting room should have the atmosphere of a rose garden.” “Halifax Medical College,” *CMAJ* 1, no. 1 (January 1911), pp. 65-66.

<sup>55</sup> “Queen's and the Carnegie Report,” *CMAJ* 1, no. 1 (January 1911), pp. 62-63.



careful selection of students.”<sup>56</sup> Within a decade, clinical experience in obstetrics became a more integral and entrenched part of medical school curricula.<sup>57</sup> In the years following the publication of the Flexner Report, the University of Toronto made its own reforms to emphasize the place of clinical instruction. A fifth year, “entirely clinical,” course on obstetrics appeared on the calendar in 1913.<sup>58</sup> Clinical requirements continued to be more explicitly articulated. By 1920, students were required to submit certificates showing they had “conducted at least twenty labours under the supervision of the Head of Department of Obstetrics and Gynaecology.”<sup>59</sup>

While Canadian medical students were required to attend an increasing number of deliveries in the years following the publication of the Flexner report, student comments, including Willinsky’s caveat, call into question the extent to which these guidelines were followed. Perhaps understandably, then, physicians well into the interwar period continued to recognize the shortcomings of their educations and described themselves as feeling thrown into obstetric practice. Born in Glencoe, Ontario, Archibald D. Campbell

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<sup>56</sup> Duffin, “The Queen’s Jews,” p. 373. See also Duffin, “Did Abraham Flexner spark the founding of *CMAJ*?” *CMAJ* 183, no. 6 (2011), pp. 811-13. Greater integration between medical schools and universities was also part of this trend. George Weisz writes that “existing medical schools at Dalhousie and Western were fully integrated into their local universities in 1911 and 1912 respectively and subsequently improved significantly.” George Weisz, “The Geographical Origins and Destinations of Medical Graduates in Quebec, 1834-1939,” *Histoire sociale/Social history* 19, no. 37 (May 1986), p. 106.

<sup>57</sup> Jacqueline Wolf argues that in the United States, this process was complete by the 1920s. Wolf, *Deliver Me From Pain*, p. 23.

<sup>58</sup> A fourth year lecture course on obstetrics “illustrated by diagrams, lantern slides, and models” introduced students to physiology and management of normal and abnormal pregnancies, while the fifth year course on obstetrics was “entirely clinical”, consisting of “demonstrations on interesting and abnormal cases.” University of Toronto, Faculty of Medicine Calendar, Session 1913-1914, pp. 71-72.

<sup>59</sup> As the University of Toronto added another year of clinical instruction in approximately 1913, these requirements were now for students sitting their sixth examination. University of Toronto, Faculty of Medicine Calendar, Session 1919-1920, p. 44; Session 1920-1921, p. 42.

(1886-1970) received his M.D. from McGill in 1911. After interning for a few years at Montreal's Royal Victoria Hospital, he remarked that his move to Alberta in the years following led him to realize, for the first time, that there were serious gaps in his experience, particularly as he "had never been taught how to make a pelvic examination."<sup>60</sup> Practicing in a remote area of Parry Sound District under the "supervision" of a Sudbury doctor over 100 kilometers away, Clifford Hugh Smylie (who would go on to receive an M.D. from Toronto in the mid-1920s) recalled feeling as though he had been left to "sink or swim," especially in obstetric cases, when he failed to receive a response to letters sent months earlier.<sup>61</sup> Likewise, William Victor Johnston recalled two weeks he spent as a student in the early 1920s assisting in the practice of an elderly doctor in Sprucedale, Ontario. After being sent to his first solo confinement by "horse and cutter" on the evening of his arrival and protesting that he had "never attended a confinement alone," his mentor assured him: "you can do better than anyone else...there is no one else there."<sup>62</sup>

Given their general lack of experience in obstetrics, many Canadian medical students found internships and other extra-curricular activities to be valuable sources of instruction. As a newly-licensed physician, Willinsky recalled taking on I.M. Rabinowitch, the son of a neighbouring Jewish family, as an assistant and intern during the latter's time in medical school at the University of Toronto in the late 1910s. By the time "Robbie" enrolled in Obstetrics in his Fourth Year, Willinsky recounted that he

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<sup>60</sup> Campbell, *Autobiography*, pp. C7-C8.

<sup>61</sup> Clifford Hugh Smylie, *Personal Memoirs*, pp. 139, 154. Clifford Hugh Smylie Fonds, MU 2853, Archives of Ontario. See also *Northern Doctor: Memoirs of Clifford Hugh Smylie, MD* (Cobalt: Highway Books, 1979).

<sup>62</sup> Johnston, *Before the Age of Miracles*, p. 14.

already had considerable experience and “was competent” in the field, often left in charge of Willinsky’s cases at one home while the doctor moved on to the next.<sup>63</sup> As an intern at Edmonton’s Royal Alexandra Hospital in the early 1920s, Samuel Peikoff lamented his lack of experience and had the sense that, given his future plans to practice medicine in a rural setting, he would “have to know how to handle a confinement.”<sup>64</sup> Unfortunately, during the first half of a semester spent interning in obstetrics (an experience which appears to have been exceptional during this period), Peikoff had yet to witness a delivery, always arriving after the child was born. He later recalled, “I had brought six placentas into the world and considered myself a placenta specialist.”<sup>65</sup> After a slow start, Peikoff appealed to the head nurse of the maternity ward, a Miss Steward, who the other interns referred to as “Old Ginger”:

I have had only three months in obstetrics. All I know is what I have read in books. I have never witnessed a delivery or brought a baby into the world. It would be hopeless for me to go into private practice so horribly ignorant. With your years of experience, I was looking forward to getting some basic training in this field. I am convinced that you know more than any of the doctors here.

Steward responded that Peikoff was the first intern she had encountered to admit that he knew “very little or nothing about actual deliveries... all you know is what you read in books,” and commented that most young doctors “sure become arrogant early in their

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<sup>63</sup> Ultimately, however, “Robbie” failed his obstetric course “because he had such extensive practice with [Willinsky’s] patients that he had never bothered to report six times to ‘observe deliveries’ and have a teaching obstetrician sign his card as evidence of attendance,” while also failing to pay the fee for the course. He went on to re-enroll at McGill, earning an M.D. in 1917 with “First Class Honours in Obstetrics and Gynecology.” Willinsky, *A Doctor’s Memoirs*, pp. 64-68.

<sup>64</sup> Peikoff described this as “a must.” Peikoff, *Yesterday’s Doctor*, p. 3.

<sup>65</sup> Peikoff, *Yesterday’s Doctor*, p. 3.

training.” By semester’s end, Peikoff had attended more than two dozen cases. Looking back on his career a half century later, he recalled that “without a doubt,” his time working under Steward represented “the most practical and useful semester in my entire year.”<sup>66</sup> As Peikoff’s example demonstrates, students could and did learn obstetrics from sources other than medical school faculty and professors. Other practitioners also reflected on their internships, both formal and informal, as the most valuable parts of their medical training.<sup>67</sup>

Regardless of the growing place of obstetrics in medical school curricula during these decades,<sup>68</sup> barriers to the subject’s full integration into medical education and the training of general practitioners continued to exist well into the interwar period. In 1925, Olafur Bjornson, Associate Professor in Obstetrics at the University of Manitoba lamented that many Canadian physicians “often looked upon obstetrics as the most drab and arduous as well as the least interesting of the three chief branches of medicine,” and cited this as the reason for “the inadequate training of the graduate of to-day in obstetrics.”<sup>69</sup> At the 1929 Annual Meeting of the Canadian Medical Association Section of Obstetrics and Gynaecology, Harold Benge Atlee, Chief of Obstetrics and

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<sup>66</sup> Peikoff, *Yesterday’s Doctor*, pp. 6-7.

<sup>67</sup> Howard J. Alexander remembered his time as an intern at Toronto General Hospital in the 1920s as “possibly one of the most interesting parts of my medical career because we were short on interns and worked all of the time.” Likewise, William Victor Johnston remembered his time working in Sharbot Lake and Barrie, Ontario, under the direction of a general practitioner with “teaching ability” as providing his “best year of instruction” and marking the occasion when he “became really enthusiastic about the practice of medicine.” Alexander, *56 Years in Medical Practice*, p. 14, and Johnston, *Before the Age of Miracles*, p. 18.

<sup>68</sup> Aside from requirements stipulating that students attend a greater number of deliveries prior to graduation, the number of hours devoted to obstetric training also increased in the post-Flexner era. The University of Manitoba, for example, increased the number of teaching hours devoted to obstetrics from 119 in 1919 to 160 in 1929. Mitchinson, *Giving Birth in Canada*, p. 55.

<sup>69</sup> Bjornson was the first Icelandic-Canadian to graduate from medical school. Olafur Bjornson, “An Obstetrical Retrospect,” *CMAJ* 15, no. 12 (December 1925), p. 1236.

Gynaecology at Dalhousie Medical School, echoing older calls for reform, stressed “the urgent necessity of better education of medical students in obstetrics.”<sup>70</sup> Calls to improve teaching in obstetrics in Canadian medical schools continued with “perennial regularity” throughout the following decades.<sup>71</sup> Nevertheless, well into the 1920s, physicians throughout North America still routinely “received medical degrees attesting to their competence to provide medical care without ever having witnessed a birth.”<sup>72</sup> Despite ongoing shortcomings of obstetric education, and the fact that many new practitioners lacked experience when it came to attending births, the turn of the twentieth century marked a key period in terms of the professionalization of obstetrics. In the instruction they did receive, medical students learned key lessons about professional conduct that allowed them to articulate their expertise and authority relative to both their expectant patients and those present in the birthing room.

### Something to Offer: Inspiring Confidence and Articulating Professional Expertise

The turn of the twentieth century marked a key moment in terms of the professionalization of obstetrics and the medicalization of birth. In the first decade of the

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<sup>70</sup> Minutes, Canadian Medical Association Section of Obstetrics and Gynaecology, Canadian Medical Association Fonds, Medical Sections, Volume 6, Folder 4, MG 28 I 343, Library and Archives Canada. For more information see Mitchinson, “H.B. Atlee on Obstetrics and Gynaecology.”

<sup>71</sup> J.T. Phair, the director of the Ontario Department of Health’s Division of Child Hygiene, commented in 1932 that amongst medical professionals, the suggestion for “a pronounced increase in the amount of time devoted to the instruction of medical students in obstetrics” was offered with “perennial regularity.” J.T. Phair, “Maternal Mortality – A General Survey,” *Canadian Public Health Journal (CPHJ)* 23, no. 4 (April 1932), p. 180. See also F.E. Rice and E.E. Bisset, “Report on Maternal Mortality,” *Public Health Journal (PHJ)* 19, no. 12 (December 1928), p. 579.

<sup>72</sup> Wolf, *Deliver Me From Pain*, p. 21.

1900s, Archibald D. Campbell described his father's negative views of both physicians and the medical profession, recounting his belief that, based on his aunt's experiences with chronic pain, most doctors had "little to offer but pomposity and laudanum." On his part, Campbell recognized that as his father was at the time over sixty years of age, his views represented the perspective of "an earlier era" and also of one living in rural Ontario. After his mother "managed to mellow Father's antipathy towards doctors," Campbell secured his father's blessing and conformed to his request that he attend McGill, which was, according to the senior Campbell, "the finest medical school."<sup>73</sup> Within the Campbell family, views of the medical profession appear to have been changing. Throughout this transformative period, on a broader level, older prejudices against mainstream, licensed practitioners (physicians) increasingly gave way to growing respect for the "modern" and "scientific" medical profession.<sup>74</sup> Physicians appear to have been well aware of the need to reform the image of the mainstream medical practitioner, presenting medical students with a variety of lessons on professional conduct, in the hopes that these would enable the future doctor to articulate his expertise relative to patients and other practitioners.

These messages were regularly presented to students in many of the leading medical textbooks of the period. While the majority of the texts assigned to Canadian medical students in the late nineteenth and early twentieth centuries were not written by Canadians, instead claiming British or American authorship, they were actively read by

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<sup>73</sup> Campbell, *Autobiography*, p. A79.

<sup>74</sup> For more on this process see R.D. Gidney and W.P.J. Millar, *Professional Gentlemen: The Professions in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1994).

both aspiring and active Canadian physicians.<sup>75</sup> These volumes represented, as Mitchinson suggests, “the orthodoxy of the medical profession,” along with the consensus of leading researchers in field, and also offered an image of how the profession, and the burgeoning specialty of obstetrics, sought to represent itself.<sup>76</sup> On a more practical level, as the majority of Canadian medical students at the turn of the twentieth century had “neither the opportunity nor time for efficient clinical work”, medical textbooks and lectures were often “the main source of information” for many young practitioners.<sup>77</sup>

Medical texts could be a close reflection of the content presented in lectures and demonstrations in obstetrics at Canadian medical schools. This was the case with Kenneth Fenwick’s 1889 *Manual of Obstetrics, Gynaecology, and Pediatrics*, which the Queen’s University Professor described as “really a syllabus of my sessional lecturers with such additions and alterations as I thought would make it more valuable for reference in emergencies.”<sup>78</sup> David Tod Gilliam, Professor of Gynecology at Sterling Ohio Medical College, based the chapter organization of his *Text-Book of Practical Gynecology* (1907) on “the number of lectures and recitations usually allotted to the subject during a collegiate term.”<sup>79</sup> Likewise, Adam Wright divided his 1908 volume into two sections, devoted to Physiological and Pathological Obstetrics, based on the topics

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<sup>75</sup> This study relied on an examination of 35 texts - 21 authored by Americans, nine authored by British physicians, and five by Canadians. Canadian examples will be highlighted wherever possible.

<sup>76</sup> See Mitchinson, *Giving Birth in Canada*, p. 15.

<sup>77</sup> John Hunter, “Half a Century in Medicine, 1875-1925,” *CJMS* 64, no. 3 (September 1928), p. 71.

<sup>78</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, preface.

<sup>79</sup> The book was divided into fifty chapters. David Tod Gilliam, *A Text-Book of Practical Gynecology: For Practitioners and Students* (Philadelphia: F.A. Davis, 1907), preface.

presented in the University of Toronto's third and fourth year courses on the subject. He positioned his text as a volume "published at the request of students and fellow practitioners," and based his knowledge on "an intimate association with students and physicians and a careful study of their wants."<sup>80</sup> *The Principles and Practice of Obstetrics*, a popular 1913 medical text published by Joseph B. DeLee, who would go on to be described as "the father of modern obstetrics," evolved out of a previous volume (*Notes on Obstetrics*) long used as the chief accompaniment to the author's lectures at Northwestern University.<sup>81</sup> In the post-World War II period, William Albert Scott and H. Brookfield Van Wyck, Professor and Assistant Professor in Obstetrics and Gynaecology described their text, *The Essentials of Obstetrics and Gynaecology* (1947) as "guided by the scope and detail of the basic course of lectures given to the undergraduate years in the Faculty of Medicine, University of Toronto."<sup>82</sup>

Even in those texts not written as an explicit accompaniment to medical school course content, physician-authors were careful to emphasize their credentials in the teaching and practice of obstetrics. J. Clifton Edgar, Professor of Obstetrics and Clinical Midwifery at Cornell University, emphasized that his text, *The Practice of Obstetrics* (1907) was "founded upon fifteen years' work in maternity hospitals and in bedside and didactic teaching."<sup>83</sup> Barton Cooke Hirst, Professor of Obstetrics at the University of

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<sup>80</sup> Wright, *A Text-Book of Obstetrics*, v, vi.

<sup>81</sup> Joseph B. DeLee, *The Principles and Practice of Obstetrics* (Philadelphia: W.B. Saunders, 1913), preface. See also Wolf, *Deliver Me From Pain*, pp. 20-21.

<sup>82</sup> William Albert Scott and H. Brookfield Van Wyck, *The Essentials of Obstetrics and Gynaecology* (Philadelphia: Lea & Febiger, 1947), p. 3. Scott and Van Wyck's text is representative of another point made by Mitchinson – the fact that Canadian-authored texts were not always published by Canadian imprints. Mitchinson, *Giving Birth in Canada*, p. 15.

<sup>83</sup> J. Clifton Edgar, *The Practice of Obstetrics: Designed for the Use of Students and Practitioners* (Philadelphia: P. Blakiston's Son & Co., 1907), preface.



Pennsylvania, cited his extensive teaching experiences “in clinics, hospitals, laboratories, and in the lecture-room...during the whole of his professional career.”<sup>84</sup> Likewise, John Fairbairn, Lecturer in Midwifery and the Diseases of Women and examiner at the Universities of Oxford, Cambridge, London, and Leeds, pled “twenty-five years of hitherto blameless service as a teacher and nearly twenty as an examiner” as his reason for daring to add to “the glut of students’ textbooks” on midwifery and obstetrics. He framed his 1924 work as “a fair compromise” between professional ideals and “the requirements of the medical curriculum and the examination room.”<sup>85</sup> Authorship appears to have been a point of pride and a source of prestige for many physicians, who were regularly recognized as some of the leading names in the field. Of course, other practitioners took the opposite view. The son of Dr. Frances Henry Champneys (1848-1930), one of the British pioneers of modern obstetrics, recalled, for example, that his father would never write a textbook because of both the pressure to conform to publishing conventions – “no publisher would consent to having some pages occupied by a single sentence in enormous type, to drive home an important lesson” – and “the labour involved in keeping it up to date.”<sup>86</sup>

Texts often represented a compendium of the most widely accepted theories and standards of practice in obstetrics, with authors, at times, explicitly identifying this in their volumes. Charles A.L. Reed, Clinical Lecturer on the Surgical Diseases of Women at Cincinnati Hospital and President of the American Medical Association, positioned his

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<sup>84</sup> Hirst, *A Text-Book of Obstetrics*, p. 11.

<sup>85</sup> John S. Fairbairn, *Gynaecology with Obstetrics: A Text-Book for Students and Practitioners* (Toronto: Oxford University Press, 1924), v.

<sup>86</sup> “Sir Frances Champneys,” *Autobiography and Biographical Sketches*, Sir Weldon Dalrymple-Champneys Collection, GC/139/C.2, Wellcome Library.

1901 *Text-Book of Gynecology* as “a working manual for practitioners and students,” describing the text as having embraced “the best approved developments in gynecology.” With particular topics assigned to “a considerable number of writers, but only to those who have acquired reputation in connection with the subjects upon which they were asked to write,” the volume drew on the expertise of a number of influential practitioners and teachers, including Canadians Wyatt G. Johnston, Bacteriologist and Pathologist at McGill, and James F.W. Ross, Lecturer in Clinical Gynaecology at the University of Toronto.<sup>87</sup> Likewise, Queen’s Professor of Obstetrics and Gynaecology R.W. Garrett positioned his 1910 text as having interwoven “the opinions of those who represent the most recent and advanced thought, and those who have been separated out for distinction in the subjects upon which they have written.”<sup>88</sup> Other texts were written from and emphasized a particular viewpoint. J. Whitridge Williams, Professor of Obstetrics at Johns Hopkins University, was one of the more conservative obstetricians of the era who continued, in the face of increasing pathologization, to argue that birth was “primarily a physiological event requiring skilled and attentive but largely hands off medical care.”<sup>89</sup> Based on this perspective, in the 1931 edition of his text, in use at McGill University, he “endeavored to emphasize the conservative aspects” of obstetrics “as is fitting a work intended for the instruction of students and the guidance of practitioners, in the hope of counteracting to some extent the radical views so frequently expressed in current

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<sup>87</sup> Charles A.L. Reed, *A Text-Book of Gynaecology* (New York: D. Appleton and Co., 1901), v.

<sup>88</sup> Garrett, *Text Book of Medical and Surgical Gynaecology*, preface.

<sup>89</sup> Wolf, *Deliver Me From Pain*, p. 2. For more on the pathologization of pregnancy and birth during this period, see Chapter 2.

literature.”<sup>90</sup> Despite the various approaches and perspectives of textbook authors, medical students and new practitioners were expected to be widely read in the field of obstetrics.<sup>91</sup>

Regardless of author perspective, the majority of texts placed emphasis on the same core set of professional standards that the medical student and young practitioner needed to develop. These attributes were framed as necessary to allow the medical practitioner to articulate his expertise relative to both expectant patients, and others in attendance in the birthing room. While the physician’s authority relative to his patients would ideally be established early on – with the roots of the doctor-patient power dynamic already in place for those general practitioners and family physicians who had effectively guided young women “from infancy through the various stages of life up to womanhood”<sup>92</sup> – the fact that most women, well into the twentieth century, continued to give birth in the home often posed a challenge to professional authority.

In Ontario, arguably the most “modern” and medicalized Canadian province, the majority of births nonetheless took place in the home until 1938.<sup>93</sup> Though hospitalized births became increasingly popular in the first decades of the twentieth century, especially in urban areas,<sup>94</sup> the personal narratives of Canadian medical students and

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<sup>90</sup> J. Whitridge Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, 6<sup>th</sup> Enlarged and Revised Edition (New York and London: D. Appleton and Company, 1931), preface.

<sup>91</sup> Fenwick, for example, suggested that his work, though intended to be of particular use for students in his own courses, did not “aim at supplanting the larger text books on the subject.” Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, preface.

<sup>92</sup> Edgar, *The Practice of Obstetrics*, p. 39.

<sup>93</sup> Oppenheimer, “Childbirth in Ontario,” pp. 36-60.

<sup>94</sup> Though Gagan and Gagan write that by the 1920s, Canadian public hospitals had achieved a reputation as centres of “diagnostic efficacy, technical innovation, and surgical accomplishments,” numbers of maternity cases took off later in the decade as public and

practitioners suggest that home deliveries were perceived as the norm well into the interwar period. Samuel Peikoff recounted that while practicing “bush country” obstetrics in rural Rosburn, Manitoba, during the 1920s “all of [his] confinements were done at home. A doctor was only called in after the mother had been in labour at least a day or two.”<sup>95</sup> William Victor Johnston echoed this assessment, describing one of the first births he attended as a novice in the early 1920s as “unusual” in that it had taken place at the hospital.<sup>96</sup> Howard Alexander, who practiced in Tillsonburg, Ontario, recalled that house calls and home deliveries “were the usual way of practicing medicine in the dirty thirties, because the people at that time were trained, possibly by the previous family members, to expect the doctors to come to the house and that was more or less a routine.”<sup>97</sup> As late as 1946, Canadian medical students were presented with information, put forward by Canadian authors, that “the greater proportion of births takes place in the home.” Though the number of hospitalized deliveries in Canada was described as “gradually increasing,” some learned that these figures were “still amazingly low.”<sup>98</sup> Nevertheless, practitioners and students did seem to make note of the growing move towards hospitalized birth, with

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professional concerns surrounding infant and maternal mortality led to increasing emphases on the safety of hospital births as opposed to home deliveries. Gagan and Gagan argue that “by 1940, the institutionalization of childbirth across Canada was very nearly complete.” Gagan and Gagan, *For Patients of Moderate Means*, pp. 4, 171-172.

<sup>95</sup> Peikoff, *Yesterday's Doctor*, p. 27.

<sup>96</sup> Practicing in Lucknow, Ontario, Johnston wrote that “it was not until well after the mid-twenties that hospital confinements became popular and I could refuse to accept pregnant patients unless they agreed to go into a hospital.” Johnston, *Before the Age of Miracles*, p. 36.

<sup>97</sup> Alexander, *56 Years in Medical Practice*, p. 21.

<sup>98</sup> This passage came from a text intended for student nurses, and perhaps is indicative of the fact that nurses often attended patients in the home for prolonged periods, both before and after delivery, especially when compared with their physician counterparts. Archibald D. Campbell and Mabel A. Shannon, *Gynaecology for Nurses* (Philadelphia: F.A. Davis Company, 1946), p. 77. Campbell, a McGill MD, went on to become Associate Professor of Obstetrics and Gynaecology at McGill. Shannon was supervisor of the Gynaecological Ward at Montreal General Hospital.

U of T Professors Scott and Van Wyck pointing out in 1947 that “the trend is toward hospital delivery in urban centers, and hospital facilities are becoming more available in rural communities.”<sup>99</sup>

Despite this trend, the majority of physicians in the late nineteenth and early twentieth centuries rarely saw their patients until they were called to deliver. Though students were instructed to “always” examine their patients early in pregnancy to identify any abnormalities or potential problems, the realities of obstetric practice were very different.<sup>100</sup> Textbook authors, particularly in the first decades of the twentieth century, often ignored or glossed over the experiences and circumstances their students would face in the birthing room, both in the images they presented of the settings in which the young practitioner would be called upon to confine women (see Figure 1.3), and in their descriptions of the doctor-patient relationship. Adam Wright suggested in 1908 that “the accoucheur will generally have seen the patient before labour,” and recommended that future physicians make a point to carry out at least a week of daily postnatal visits to their patients, followed by visits every two to three days thereafter for the first three weeks of the postpartum period. He did qualify that “such directions apply especially to attendance on patients in cities or towns,” recognizing that “in many country districts, the physician in certain cases makes no subsequent visits after attending the patient in confinement.”

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<sup>99</sup> Scott and Van Wyck, *The Essentials of Obstetrics and Gynecology*, p. 93. Between 1933 and 1937, more than half the births in Manitoba occurred in hospital. F.W. Jackson, N.R. Rawson, and Ernest Couture, “Maternal Mortality in Manitoba,” *CPHJ* 31, no. 7 (July 1940), p. 318. See also, Ernest Couture, “Child and Maternal Hygiene in the Postwar Period: The Need for Planning Now,” *Canadian Journal of Public Health (CJPH)* 36, no. 3 (March 1945), p. 99.

<sup>100</sup> J.M. Smith, Lecture Notes on Obstetrics (as taken from Dr. Meek or Dr. Eccles), University of Western Ontario, 1900, A00-194-01, Archives Research and Collections Centre, Western University.

**Figure 1.3**



FIG. 63.—ROOM PREPARED FOR LABOR.

Room prepared for labour, early twentieth century. Students were advised to make their preparations based on a hospital-style model, despite the fact that the majority of deliveries continued to take place in the home well into the twentieth century. Adam Wright, *A Text-Book of Obstetrics* (New York and London: D. Appleton and Company, 1908), p. 92. Not in copyright.

Wright ultimately argued, however, that no physician “should take responsibility for conducting a case of labour without seeing his patient at least once or twice after the birth of the child.”<sup>101</sup> On his part, Fairbairn recognized that practitioner experiences and prenatal visits varied from case to case, and patient to patient, usually “according to the social status and education of the woman.”<sup>102</sup> Textbook authors, therefore, appear to have made two assumptions: first, that their parturient patients would generally be a specific group of women – those hailing from urban areas and the well-to-do classes – and

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<sup>101</sup> Wright, *A Text-Book of Obstetrics*, pp. 85, 153-154.

<sup>102</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 107

second, that the majority of medical students and future physicians would, for the most part, practice in urban settings.<sup>103</sup>

Other texts offered a more realistic perspective. Fenwick, for example, recognized the reality that the first contact between the physician and his parturient patient often took place in the birthing room. He advised his students to, during delivery, “enquire into the history of the case, such as the length of previous labours, her health during pregnancy, the number of previous pregnancies, whether she is now up to full time, when the pains began, as to their frequency and situation, and if the membranes have ruptured.”<sup>104</sup> Many of these more rudimentary aspects of the patient’s history would have, presumably, been addressed in any earlier visits. Fenwick was, however, writing in the late nineteenth century. Other practitioners suggested that pre-natal care appeared to be increasing by the early decades of the twentieth century, while still recognizing variations depending on the circumstances of the parturient patient. Writing from an American perspective, DeLee reported in 1913 that “women call the doctor and engage him for their confinement earlier now than formerly, earlier among the better classes than the poorer, earlier in the city than the country, earlier in the United States than in most other lands.”<sup>105</sup> North of the border, Cynthia Comacchio has suggested that public health efforts to promote prenatal care and an emphasis on the need for medical supervision throughout the entire period of pregnancy reached new heights in the interwar period.<sup>106</sup> For many practitioners, however, the first point of contact remained the birth itself. Clifford Hugh

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<sup>103</sup> Mitchinson, *Giving Birth in Canada*, p. 15.

<sup>104</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 61.

<sup>105</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 225.

<sup>106</sup> Comacchio, *Nations are Built of Babies*, pp. 66-91.

Smylie recalled of his Parry Sound practice in the 1920s: “Rarely would I see a maternity case until I was called to deliver her, and then usually only after she had been in labour a long time, and the neighbor woman with her had decided something must be wrong.”<sup>107</sup> The fact that physicians were regularly called at the last minute, particularly in cases that were perceived as problematic or abnormal, undoubtedly contributed to the predominance of increasingly pathological views of pregnancy and birth amongst Canadian practitioners.

Often called into the homes of their expectant female patients on short notice during the labour process, Canadian physicians could be unaware of the potential audiences they would encounter in the birthing room. This factor was seen as having the potential to impede the obstetrician’s practice, especially for beginners lacking experience in the field. In his 1912 text, Hirst highlighted the “most unenviable frame of mind in the practitioner attending his first few cases of labour,” fuelled by “the knowledge that his every movement is watched by critical friends or attendants of the patient, who possess, perhaps, just what he lacks – practical experience.”<sup>108</sup> The presence of the patient’s husband, in particular, had the potential to challenge gendered power dynamics. In his lessons to Toronto medical students in the early twentieth century, Wright identified this complication, pointing out that “it occasionally happens that a husband desires to be present during labour, although why he should do so I could never understand.”<sup>109</sup> Wright went on to describe his custom of allowing the husband to remain,

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<sup>107</sup> *Personal Memoirs*, Clifford Hugh Smylie Fonds, p. 154.

<sup>108</sup> Hirst, *A Text-Book of Obstetrics*, p. 170.

<sup>109</sup> Though largely focused on a later period, Judith Walzer Leavitt has complicated assumptions about the historical trend of male exclusion from the birthing room. See Judith Walzer Leavitt, *Make Room for Daddy: The Journey from Waiting Room to Birthing Room* (Chapel Hill:



if he desired, during the first stage of labour, though he asserted that the physician would likely “much prefer his absence.” He continued:

He can do no good and is apt to be intensely alarmed on account of his wife’s sufferings. Under the circumstances he becomes sometimes an intolerable nuisance, and it will keep one pretty busy assuring him that this is not the first time in the history of the world that a woman has suffered so severely. During the progress of the second stage I generally say, quietly, ‘You had better leave the room now, we are getting near the end,’ without giving any reasons why. He almost invariably leaves without making any trouble. If by any chance he should insist upon remaining, I have nothing more to say.<sup>110</sup>

However undesirable the prospect of having an audience might have been for the new practitioner, the presence of others in the birthing room could also provide a valuable safeguard to the physician’s professional reputation. Students were routinely taught that in the presence of any abnormality or complication, “the husband or near relative” of the parturient patient ought to be informed as soon as possible “for the doctor’s own protection.” Students were advised, however, not to explain complications to the expectant mother “until it is needful to interfere, when the conditions are to be gently, kindly, and with great tact explained to her.”<sup>111</sup> The presence of a third party also protected the physician from “false accusations, honestly made” of sexual impropriety from the anaesthetized patient.<sup>112</sup> Throughout the first half of the twentieth century,

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University of North Carolina Press, 2009). More evidence showing fathers’ desire to be involved in births is provided in Chapter 6.

<sup>110</sup> Wright, *A Text-Book of Obstetrics*, p. 104.

<sup>111</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 290.

<sup>112</sup> Harry Sturgeon Crossen, Professor of Gynaecology at Washington University Medical School argued in his 1917 volume that “Anaesthesia or partial anaesthesia of a girl or woman without a third party present is hazardous for another reason. The patient, while going under the anaesthetic or recovering from the same, may experience certain feelings or hallucinations that cause her really to believe and firmly proclaim that sexual intercourse took place. Many such cases of false

physicians often anticipated an audience in the birthing room. As a result, the medical practitioner's appearance and demeanor became a key component of his professional identity and reputation as an experienced and dependable birth attendant.

With the medicalization of childbirth already underway by the mid-Victorian period, physicians of that time increasingly emphasized the need for medical men to behave appropriately and maintain a respectable professional demeanor in the birthing room. Cautioning the medical student of the dangers of assuming "a tone of familiarity" with his female patients that had the potential to be "construed into impertinence, or downright insult", American obstetrician Charles Meigs advised future practitioners to exhibit towards the expectant mother "the most profound respect and sympathy...proffered with a sincere conviction of the painful nature of her position, as well as the indispensable propriety and necessary submission to it."<sup>113</sup> Students were taught that different classes of women demanded varying levels of courtesy. Gunning Bedford, Professor of Obstetrics at the University of New York, described the proper method for turning back one's coat and shirt sleeve and pinning a napkin over the wrist prior to examination in his 1861 text. In noting that such a method was "more in keeping with neatness and refinement, two attributes always well appreciated in her physician by a delicate and cultivated female," he insinuated that well-to-do patients required greater respect than their working class counterparts.<sup>114</sup>

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accusations, honestly made, are on record." Harry Sturgeon Crossen, *Diseases of Women* (St. Louis: C.V. Mosby Company, 1917), p. 1118.

<sup>113</sup> Charles Delucena Meigs, *Obstetrics: The Science and the Art* (Philadelphia: Blanchard and Lear, 1852), p. 281.

<sup>114</sup> Gunning S. Bedford, *The Principles and Practice of Obstetrics* (New York: Samuel S. & William Wood, 1861), p. 198.

Professionalism and courteous conduct was all the more necessary given the perceived emotional condition of the parturient patient. In his 1870 *Treatise on the Theory and Practice of Obstetrics*, William Heath Byford, Professor of Obstetrics and Diseases of Women and Children at the Chicago Medical College, advised students that because the expectant mother was generally “more or less excited, and some of them impatient and petulant,” any “misbehavior” on the part of the patient “should be met by the utmost kindness and indulgence.”<sup>115</sup> Into the early twentieth century, physicians were urged to “remember that the irritability and increased sensibility characteristic of pregnancy are even more exaggerated during labor.” As a result, the medical practitioner’s appearance, habits, and demeanor could easily sour the doctor-patient relationship. While Barton Cooke Hirst admitted that the general advice to young practitioners “in regard to their personal demeanor and appearance when about to attend a woman in labour...is usually superfluous,” he advised his students to remember that “any unusual appearance of the medical man – slovenliness of dress, abruptness of speech and manner, harshness of voice, the odor of the liquor on his breath or of tobacco in his clothing – may disgust his patient.”<sup>116</sup> Similarly, Adam Wright urged his students to exercise “the rather useful commodity which is ordinarily called tact” in all their actions in the birthing room – by being sure “never to give way to anger” though the parturient patient was “apt, in her semi-delirium, to say some rather uncomplimentary things,” and by regularly excusing himself from the birthing room to protect the delicate modesty of

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<sup>115</sup> William Heath Byford, *A Treatise on the Theory and Practice of Obstetrics* (New York: William Wood & Co., 1870), pp. 220-221.

<sup>116</sup> Hirst, *A Text-Book of Obstetrics*, p. 183.

the patient.<sup>117</sup> For Wright, a key component of professionalism was the appearance of the young practitioner. He took particular issue with obstetricians' reluctance, unlike surgeons, to dress themselves in a fresh and clean gown or apron, noting that "many of them simply take off their coats and roll up their sleeves within sight of the patient, and look sometimes as if preparing for a fight." Highlighting the effects that this action could have on the unequal, fragile, and deeply gendered doctor-patient power relationship, Wright suggested that "the sight of a big muscular doctor thus preparing to treat a poor, delicate, little woman generally causes fear and trembling."<sup>118</sup>

Increasingly seeking to represent themselves and their profession as attuned and sympathetic to the plight of their expectant patients, physicians adopted pain-related language to describe their own experiences and feelings in the birthing room.<sup>119</sup> Meigs, for example, wrote in his 1852 volume that he instructed students how to approach difficult labours based on the "painful experiences" he had encountered in cases of pelvic deformities, looked forward with "painful anxiety" to the outcome of forceps cases, and had "painful misgivings" about suspected cases of puerperal fever in his patients. He warned the future practitioner that, understandably, "there is nothing to be met with in the very troublesome and anxious profession of an obstetrician, that is more painful to his feelings than the management of a case of labor in which it is required to mutilate the child, in order to extract it from the maternal organs."<sup>120</sup> Other physicians followed suit,

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<sup>117</sup> Wright recognized that in practice, "among the poorer classes" there was often "no second room to which one may retire. In such a case there is no necessity for worry, as the patient will be forced to adapt herself to the circumstances in which she is placed." Wright, *A Text-Book of Obstetrics*, pp. 85, 101.

<sup>118</sup> Wright, *A Text-Book of Obstetrics*, p. 95.

<sup>119</sup> Joanna Bourke has argued that the nineteenth century marked a key period in terms of changing understandings of medical sympathy. For more on this, see Chapter 5.

<sup>120</sup> Meigs, *Obstetrics: The Science and the Art*, pp. 516, 544, 565, 620.

and to varying degrees, modelled this language to their own students. In his 1861 text, Bedford cautioned students of the “painful consequences” faced by the physician who suffered poor judgement and assisted a patient in aborting a child, but also used the same language to describe the “painful sensation” the accoucheur experienced around his wrist upon passing his hand into the uterus to perform a version.<sup>121</sup> Byford recalled a “painful interview” he had with a patient’s husband at the conclusion of a difficult case in which he was advised to save the mother at the expense of the infant.<sup>122</sup>

While it is impossible to know if or how this shared language of pain and sympathy had any bearing on the doctor-patient relationship and the events taking place in the birthing room, medical textbooks from the period readily acknowledged the role that the physician’s words could play in shaping the trajectory of births. In his 1870 volume, Byford cautioned students that labour pains could be significantly “enfeebled...by the announcement that [instrumental or surgical] interference will probably be necessary.”<sup>123</sup> The physician’s demeanor and the emotional atmosphere of the birthing room were also thought to have an impact on the progress of labour. Byford also recounted a case in which the unexpected death of her husband in the birthing room rendered the pains of “a young lady sick in her first labor... so feeble and inefficient as to require artificial [forceps] delivery.” He concluded that “discouragement” of all types often had adverse effects.<sup>124</sup> The very presence of the physician could have the same result. In his 1878 text, *Notes from Lectures on Obstetrics*, Columbia University

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<sup>121</sup> Bedford, *The Principles and Practice of Obstetrics*, pp. 137, 270.

<sup>122</sup> Byford, *A Treatise on the Theory and Practice of Obstetrics*, p. 409.

<sup>123</sup> Byford, *A Treatise on the Theory and Practice of Obstetrics*, p. 281.

<sup>124</sup> Byford, *A Treatise on the Theory and Practice of Obstetrics*, pp. 280-281.

Professor of Gynaecology Theodore Gaillard Thomas suggested that “even the entrance of the doctor” often contributed to “tedious labor.”<sup>125</sup> Canadian medical students also learned that physical examinations, posing a particular affront “to the sensibilities of the patient” had, “in many cases a bad effect on the nervous system,” delaying the progress of labour. Physicians asserted that experience, often lacking in new practitioners, was the best safeguard against unnecessary and repeated physical examinations.<sup>126</sup>

### Expert Interpretations of the Sights, Sounds, and Sensations of Childbirth

The leading medical texts of the late nineteenth and early twentieth centuries demonstrate that pelvic examinations were a persistent source of anxiety for both practitioners and patients. Recognizing the value of the exam in aiding diagnosis, doctors were advised to tactfully negotiate the complexities involved with administering a gynecological examination with their parturient patients. In his 1878 text, Thomas advised his students to “always approach your patient directly upon the subject. Inquire about former labors, symptoms, etc. When the ice is thus broken, make a vaginal examination, having previously directed the nurse to prepare the woman for it.”<sup>127</sup> Wright recognized that all pelvic exams were “more or less distasteful to the patient” but suggested that certain women experienced more discomfort than others, describing the

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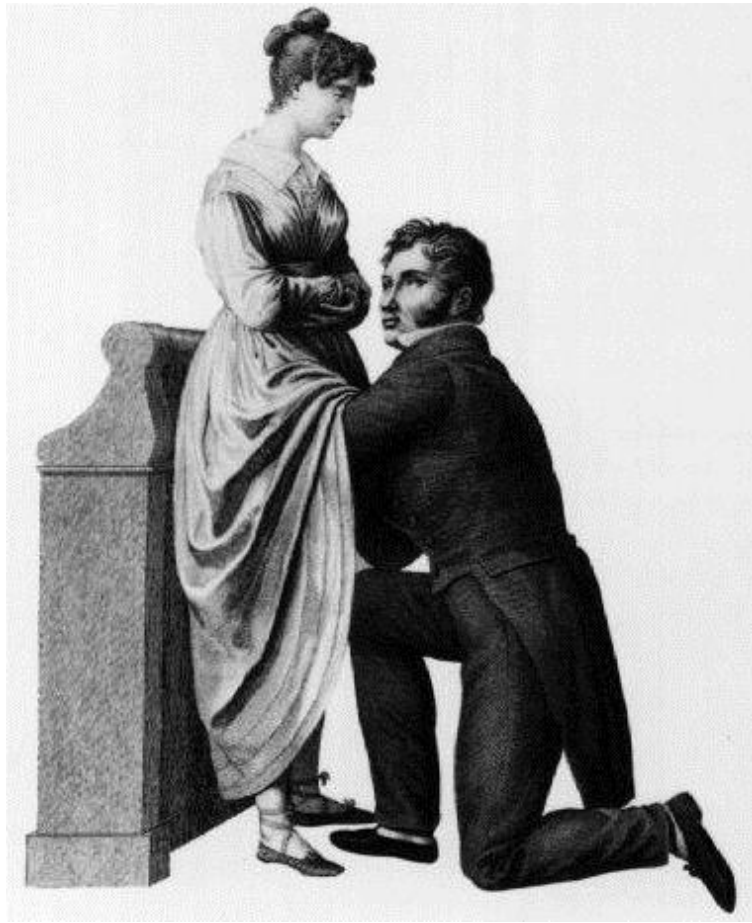
<sup>125</sup> T.G. Thomas, *Notes from Lectures on Obstetrics* (New York: John J. O’Brien, Steam Book & Job Printer, 1878), p. 33.

<sup>126</sup> Edgar, *The Practice of Obstetrics*, p. 477.

<sup>127</sup> Thomas, *Notes from Lectures on Obstetrics*, p. 27.

modern practice of digital examination, as opposed to older methods (see Figure 1.4), as involving “an exposure so marked that the sensitive woman naturally shrinks from it.”<sup>128</sup>

**Figure 1.4**



Early nineteenth century representation of one method of conducting a gynaecological examination, in which the physician is kneeling before the woman but refrains from exposing her genitalia. By the late nineteenth century, this method, recognized by physicians as furnishing “incomplete results, and apt to offend sensitive patients” had largely fallen out of use. Drawing by Jacques-Pierre Maygrier (1822). Image via Wikimedia Commons. Quote from William Thompson Lusk, *The Science and Art of Midwifery* (New York: D. Appleton and Company, 1888), p. 108.

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<sup>128</sup> Wright, *A Text-Book of Obstetrics*, pp. 87-89.

The act of performing pelvic examinations could also pose a potential threat to the professional image of the physician. Though tactile examinations offered new practitioners unparalleled opportunities to learn about the bodies of their female patients, when incorrectly performed, they also had the potential to reveal professional ignorances and shortcomings in the training of the young physician. In his 1861 text, Bedford posed a cautionary question to medical students:

How are you to find the vagina? This may appear to you a very unnecessary question – but, gentle men, it is full of sterling import to you as practitioners. What would be the measure of your mortification if, in attempting an examination of this kind, the patient, after more than Christian forbearance, should exclaim, ‘Doctor, what are you about; do you not know better than that?’ and you should discover that the rebuke was prompted by the painful circumstance that, instead of the vagina, you had introduced the finger into the anus! And yet, gentlemen, strange as it may seem to you, this blunder has been committed, for want of proper knowledge, much to the chagrin of the practitioner, and the outraged feelings of the patient.<sup>129</sup>

Writing in 1901, Reed recognized the value of tactile examinations, but stressed, in his instruction to medical students, that the practitioner must always give “the impression that he is thoroughly at home in his work,” arguing that “if he betrays his inexperience by suddenness of movement, inexactitude of touch, or other evidence of the novitiate, his usefulness will be limited or destroyed.”<sup>130</sup> For young practitioners, then, both personal pride and professional reputations were at stake when it came to learning proper examination practices.

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<sup>129</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 199.

<sup>130</sup> Reed, *A Text-Book of Gynaecology*, p. 39.



Physicians were also taught that their conduct during the performance of pelvic examinations could damage their personal and professional standing in a second way. In his 1912 text, Barton Cooke Hirst provided “a word of caution” to the inexperienced physician, warning of the recent upswing in the numbers of practitioners facing “false accusations” of “attempts at assault during office examinations of female patients.” Future doctors were advised that the presence of a trained nurse in these situations could go a long way towards protecting professional reputations. Physicians “expecting to treat women” were urged to “make any sacrifice to secure the services of an office nurse, who is not only an invaluable aid in the preparation of the patient for examination and in the various methods of examination and treatment, but is also a safeguard against a serious risk of attempts at blackmail.”<sup>131</sup>

Due in part to these ongoing tensions, by the early decades of the twentieth century, medical professionals framed the “diminution in the number of necessary vaginal examinations” during confinements as “one of the great advances of modern midwifery.” In his 1910 text, Henry Jellett surmised that this progression was “only rendered possible by the possession of a certain degree of skill in the practice of abdominal palpation and auscultation, a skill which it is the duty of the student to acquire by practice on every available occasion.”<sup>132</sup> As medical professionals placed increasing emphasis on the diagnostic value of a broader range of sensory interpretations of the female body, beyond those involving touch, new practitioners were expected to perform a

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<sup>131</sup> Hirst, *A Text-Book of Obstetrics*, p. 69.

<sup>132</sup> Henry Jellett, *A Manual of Midwifery for Students and Practitioners* (New York: William Wood and Company, 1910), p. 189. Aside from having the potential to offend the sensibilities of patients, Canadian practitioners also recognized that frequent examinations during the first stage of labour were often a source of infection. See Mitchinson, *Giving Birth in Canada*, pp. 195-196.

broader and more systematic examination on the expectant patient, following, as Fairbairn suggested, “the usual medical routine of inspection, palpation, percussion, and auscultation.”<sup>133</sup> Accordingly, the modern obstetrician increasingly relied on a combination of tactile, visual, and auditory evidence to shape his understandings of the events taking place in the birthing room, most notably, the progress of labour.

As evidenced by the persistent and recurring anxieties surrounding the proper performance of pelvic examinations on female patients, physicians had long privileged touch as a means of uncovering information about the condition of the female body. In his mid-nineteenth century text, Meigs relied on the example of a “delicate female” primipara patient, “tormented with false pains for many days previous to the real attack of labor,” to instruct the medical student that “The Touch alone” would allow the practitioner to glean the necessary information required to accurately determine the progress of labour.<sup>134</sup> In his 1907 volume, Edgar emphasized the role of touch in diagnosing cases of uterine inertia, advising the medical student that a firm diagnosis was “readily made, as a rule, by palpation, which reveals the absence of a natural uterine action and the arrest of labor.”<sup>135</sup> Charles Reed offered an even stronger assessment of the value of touch in turn-of-the-century obstetric practice, writing that “by far the most important method of investigation is the examination by the fingers and hands. The tactile

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<sup>133</sup> Fairbairn wrote that “the eyes are first used to observe any peculiarity in the appearance of the abdomen, the fingers to determine the presentation and position of the foetus and the measurement of the abdominal girth, and the ears to listen for and count the foetal heart-sounds.” Fairbairn, *Gynaecology with Obstetrics*, pp. 236, 245.

<sup>134</sup> Meigs, *Obstetrics: The Science and the Art*, p. 300. Capitalization of “The Touch” in the original text.

<sup>135</sup> Edgar, *The Practice of Obstetrics*, p. 571. Thomas Watts Eden confirmed that “if the abdomen is palpated during a pain, the whole uterus will be felt to harden and become more clearly defined in outline.” Thomas Watts Eden, *A Manual of Midwifery* (Toronto: The Macmillan Company, 1915), p. 243.

sense is so acute, and may be so highly educated, as to supersede or take the place of every other method, provided one were limited to a single means of obtaining information.”<sup>136</sup> By the first decades of the twentieth century, however, the emergence of new medical technologies including the vaginal speculum posed an increasing challenge to physicians’ traditional reliance on touch, marking a growing trend of incorporating other sensory modalities – including sight and sound – into medical practice.<sup>137</sup>

Aside from the obvious utility of “hands on” interpretations, physicians were also, over the course of the late nineteenth century, increasingly taught to interpret the various sounds of labour. While recurring descriptions of the varying “cries,” “groans,” and “grunts” associated with distinct stages of labour are the most obvious example of this phenomenon,<sup>138</sup> doctors also suggested that the experienced practitioner could also draw information from other, more obscure, auditory cues. The Scottish obstetrician William Smoult Playfair, for example, was one of several practitioners to describe uterine or placental souffle to his students. Pointing out the “peculiar single whizzing murmur,” deeply affected by the uterine contractions during labour, that became “louder and more intense before the pain comes on, disappearing during its acme, and again being heard as

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<sup>136</sup> Reed, *A Text-Book of Gynaecology*, p. 35.

<sup>137</sup> Historian Kathryn Yenyurt has recently argued that “the arguments for and against the use of the speculum” in Victorian Britain “reveal interesting tensions over the potential versus the danger of privileging the sense of sight over that of touch in Victorian medical science.” Kathryn Yenyurt, “When it Hurts to Look: Interpreting the Interior of the Victorian Woman,” *Social History of Medicine* 27, no. 1 (2014), p. 23. This trend went beyond the fields of gynaecology and obstetrics, as the ability to use all the senses continued to be emphasized as one of the hallmarks of a trained physician, well into the twentieth century. See F.W. Hughes, “Diagnosis by Trained Senses,” *CJMS* 74, no. 5 (November 1933), pp. 102-104.

<sup>138</sup> See, for examples, Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 43-44; William Smoult Playfair, *A Treatise on the Science and Practice of Midwifery* (Philadelphia: Henry C. Lea, 1876), pp. 235-236; Hirst, *A Text-Book of Obstetrics*, p. 176; and J.M. Kerr et al. *Combined Text-Book of Obstetrics and Gynaecology for Students and Medical Practitioners* (Edinburgh: E. & S. Livingstone, 1923), p. 301.

it goes off,” Playfair advised future practitioners that through the skill of auscultation – listening to the internal sounds of the body – they could obtain new knowledge about the experiences of their parturient patients.<sup>139</sup> This emphasis continued into the early twentieth century.<sup>140</sup> Reflecting what Joanna Bourke has identified as a broader nineteenth century fixation on the “gestural languages” of pain,<sup>141</sup> Canadian medical students and physicians alike were urged to “cultivate their powers of observation,” taking in the “expression, action, and demeanor” of the patient in a covert or subtle manner. Upon entering the birthing room, Adam Wright advised his students to converse with their parturient patients “for a time on an ordinary topic.” He continued:

While thus talking, the physician should watch the patient carefully (without, if possible, appearing to do so). He should see and hear as much as possible and thus get a fair idea as to her general condition and also as to the particular symptoms present at the time. One can thus generally obtain an almost exact knowledge as to the frequency and severity of her pains.<sup>142</sup>

By relying on a combination of their senses and new technologies – including, most significantly the stethoscope, developed in France in the first half of the nineteenth century – rather than solely on traditional tactile examinations, medical men gained what they saw as new objective and scientific knowledge about the bodies and birthing processes of their female patients.<sup>143</sup> This knowledge allowed them to further emphasize their professional expertise in the field of obstetrics, particularly when it came to

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<sup>139</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 139.

<sup>140</sup> Edgar, *The Practice of Obstetrics*, p. 124.

<sup>141</sup> Bourke, *The Story of Pain*, p. 167.

<sup>142</sup> Wright, *A Text-Book of Obstetrics*, p. 86. See also Hirst, *A Text-Book of Obstetrics*, p. 473.

<sup>143</sup> See Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction*, Second Edition (Toronto: University of Toronto Press, 2010), p. 287.

distinguishing between “true” and “false” pains and determining the progress and efficiency of labour.

As early as the 1860s, practitioners asserted that a trained physician could interpret the pains of parturition, effectively distinguishing between “true” pains – “the offspring of a uterine contraction...synonymous with the existence of labor” – and “false” or “spurious” pains, “the product of some cause entirely foreign to uterine connection.”<sup>144</sup> Again, the ability to tactilely read the female body, grounded in a knowledge of modern, scientific obstetrics and anatomy, was at the heart of this skill. By placing a hand on the abdomen or introducing a finger into the vagina, and feeling either hardened uterus or the stiffened neck of the womb during a contraction, physicians were taught that they alone could effectively anticipate and establish the “legitimacy” of women’s pains, and thus, the effective progress of labour.<sup>145</sup> For late-Victorian obstetricians like Gunning Bedford, this was objective medical science. He advised his students: “there is no speculation here; it is a matter of fact, which you can ascertain for yourselves in the very first case of labor which may present itself to your observation.”<sup>146</sup> The ability to make such distinctions was seen as crucial to the success of the modern obstetrician. Bedford cautioned the student that without the ability to discriminate and diagnose the true and spurious pains of labour, “he will be like a ship without its rudder; his progress will not only be uncertain, but will be unsafe, and sometimes indeed,

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<sup>144</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 331.

<sup>145</sup> This emphasis on the “efficiency” of contractions or labour pains cast the parturient body as a machine, with the physician taking on the role of foreman or mechanic, seeking to ensure efficient and timely production or delivery. For more on the use of mechanistic metaphors see Martin, *The Woman in the Body*, pp. 56-57, and Comacchio, “Mechanomorphosis”.

<sup>146</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 330.

disastrous.”<sup>147</sup> As failure to recognize the “false” nature of the pains could lead one to anticipate the moment of delivery far sooner than could be reasonably expected, the young practitioner risked the patient’s frustration and disappointment, along with potential embarrassment.

Though he spoke at length on the physician’s powers of observation, Adam Wright also stressed that “it is not easy to explain the difference between the *false* pains which occur so frequently during the latter part of pregnancy and the regular or *true* pains of labor.”<sup>148</sup> In making this point, Wright placed further emphasis on the professional expertise of the modern obstetrician. Nevertheless, medical school professors in the late nineteenth and early twentieth centuries were confident that, with the proper training, future practitioners would be able to effectively make these difficult divisions. Positioning themselves as the arbiters of the distinction between “true” and “false” labour pains – and, given the fact that more and more of their female patients knew little of what to expect during the birthing process,<sup>149</sup> the sole interpreters of the events taking place during delivery – physicians effectively appropriated women’s childbirth experiences and took it upon themselves to tell the private, subjective, and personal stories of labour pain.<sup>150</sup> This process had the potential to involve the suggested denigration of patients’ own narratives or accounts of bodily experiences such as pregnancy, stories which

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<sup>147</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 331.

<sup>148</sup> Wright, *A Text-Book of Obstetrics*, p. 86.

<sup>149</sup> For more on medical perceptions of maternal ignorance, see Chapter 4.

<sup>150</sup> Yenyurt has argued that the speculum incorporated new parts of the female body into the “medical ocular economy.” In order to appropriate the female patient’s voice, the male physician “needed to literally look inside her to see what she could not tell him.” Likewise, male obstetricians relied on technology – in this case, the stethoscope – to interpret (and legitimize) private and subjective experiences of pain. Yenyurt, “When it Hurts to Look,” p. 33.

physicians described, at times, as “opinions.”<sup>151</sup> Physicians increasingly positioned themselves as the key point of contact and source of knowledge when it came to all matters related to pregnancy and birth. Once he had gained the confidence of his female patients (a process assumed to have few problems by the early 1930s), the young practitioner was advised to encourage the expectant mother “to come to him whenever anything occurs to worry her, instead of taking advice from her women friends.”<sup>152</sup> On some occasions, physicians were also advised to actively withhold knowledge from their female patients.<sup>153</sup> The justification for these decisions, based on the evolving authority and expertise of the obstetrician, went hand in hand with broader descriptions of the generally untrustworthy nature of the female patient.

In several popular medical texts of the period, practicing physicians warned their students of the problems that could arise from blindly trusting their female patients. On the most basic level, Wright suggested that the young practitioner, in asking the patient about her pains, “without appearing to have any doubt on the subject...should try to satisfy himself that she is pregnant and try to ascertain whether she is in labor.”<sup>154</sup> Recounting a case where he was “deceived” by a 34 year old unmarried female patient experiencing excessive menstrual bleeding, ultimately operating and removing both the ovaries and uterus, the latter of which contained a healthy fetus at roughly three months

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<sup>151</sup> Advising the future physician to inquire as to the number of former pregnancies on a first visit (often at the moment of birth) and ask the patient if she had reached full term, Wright asserted that “she may think that she has or has not and will probably give her reasons for such opinions.” Wright, *A Text-Book of Obstetrics*, p. 87.

<sup>152</sup> Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 247.

<sup>153</sup> In his 1888 text, Fenwick advised Canadian medical students, “if asked as to the duration of labour”, to “be guarded and possibly ambiguous.” Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 61. Mary-Ellen Kelm has argued that physicians, at times, adopted a similar strategy in their encounters with Indigenous patients. Kelm, *Colonizing Bodies*, p. 162.

<sup>154</sup> Wright, *A Text-Book of Obstetrics*, pp. 86-87.

gestation, Peikoff concluded that the medical practitioner “cannot always believe the patient’s story when there is a possibility of pregnancy.”<sup>155</sup> Fairbairn made this point explicitly clear in his 1924 text. He advised future practitioners that “the patient’s statements, particularly in those cases in which she may have some object in either concealing or feigning pregnancy, should be accepted with extreme caution.”<sup>156</sup>

With their authority over their parturient patients largely established by the early twentieth century, physicians were increasingly asked to weigh in on and provide assistance to their patients in ways that reflected their growing role as moral authorities in the community. Abraham Willinsky recalled that during his time spent working in Toronto in the years surrounding the First World War, he was, on at least one occasion, called upon to examine a girl and testify to her virginity to her fiancé and his family.<sup>157</sup> Likewise, Samuel Peikoff, practicing in rural Manitoba in the late 1920s, remembered reassuring one woman, forced to postpone her wedding due to an outbreak of scarlet fever but already pregnant with a potentially illegitimate child, that he would assure her father that the baby was premature, with no one the wiser.<sup>158</sup> Such requests can be interpreted as a reflection of the medical practitioner’s growing respectability, authority, and expertise in the eyes of many Canadians. At the turn of the twentieth century, physicians also sought to articulate and emphasize these traits in their interactions with the other practitioners and health care providers they encountered in the birthing room.

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<sup>155</sup> Peikoff, *Yesterday’s Doctor*, p. 106.

<sup>156</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 109.

<sup>157</sup> Willinsky ultimately refused this request. Willinsky, *A Doctor’s Memoirs*, p. 70.

<sup>158</sup> Peikoff, *Yesterday’s Doctor*, p. 53.



## Professional Rivalries

Though the majority of deliveries were taking place in the home throughout the first half of the twentieth century, a key part of both the professionalization of obstetrics and the obstetrician's professional reputation and appeal was an emphasis on the modern comforts, including anaesthesia, that physicians could offer their patients. Such services also allowed physicians to distance themselves from other practitioners, including midwives and nurses, who might also be attending women in labour. Canadian medical students were regularly and consistently advised that anaesthetics had to be administered carefully, under the physician's authority and control, by medically-trained personnel.

In his 1888 text, *The Science and Art of Midwifery*, William Thompson Lusk advised medical students that the "cautious and intelligent administration" of anaesthetics should always "be directed and supervised by the physician."<sup>159</sup> Physicians, however, appear to have recognized the existence of extenuating circumstances that posed a challenge to this type of administration, and texts provided some comment on these. Medical texts also advised future practitioners that unexpected complications, including the type that might call for a forceps delivery, might require the physician to "leave the continuance of the chloroform or ether-giving to any intelligent bystander who acts under his supervision."<sup>160</sup> Who exactly qualified as an "intelligent bystander" appears to have been the subject of a great deal of interpretation and debate well into the twentieth century.<sup>161</sup> In these discussions, physicians sought (often simultaneously) to both make

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<sup>159</sup> Lusk, *The Science and Art of Midwifery*, p. 229.

<sup>160</sup> Lusk, *The Science and Art of Midwifery*, p. 359.

<sup>161</sup> In 1926, Dr. Samuel Johnston commented that the Canadian consensus in the first quarter of the twentieth century often seemed to be that "almost anyone who could hold a mask and pour on

use of the assistance offered by other figures in attendance in the birthing room, and articulate their superior knowledge and expertise in obstetrics relative to other categories of health practitioners.

By the second half of the nineteenth century, Canadian medical students were regularly taught that the skillful management of pathological cases and difficult births, including, for example, cases of dystocia (slow, difficult, or abnormal labour) or placenta previa (where the placenta wholly or partially blocks the neck of the uterus), distinguished “the educated accoucheur from the ignorant midwife.”<sup>162</sup> As all labours were increasingly pathologized and seen as potentially abnormal or problematic, requiring this level of skillful care,<sup>163</sup> professional expertise in obstetrics was framed as essential. While physicians continued to lobby against midwifery (effectively outlawed since the late nineteenth century) and emphasized midwives’ lack of skill as one of the key reasons behind the decline of traditional female-dominated cultures of childbirth, individual doctors had varying experiences in working with midwives.<sup>164</sup> Practicing west of Winnipeg, Manitoba in the first decade of the 1900s, Wilfred Abram Bigelow described one of his first encounters with an elderly midwife, who had requested to “quill” a patient in a January 1908 case. Though he had never heard of the practice, Bigelow did not want to reveal his ignorance to the senior (and, in all likelihood, more

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some drug was allowed to administer an anaesthetic.” Samuel Johnston, “An Address on the Growth of the Specialty of Anaesthesia in Canada,” *CMAJ* 17, no. 11 (November 1927), p. 814.

<sup>162</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 84-85.

<sup>163</sup> For more on this, see Chapter 2.

<sup>164</sup> Historians have suggested that the gradual elimination of midwifery in early twentieth century Canada can be attributed to several factors, but that “the unrelenting and powerful opposition of the organized medical profession, which used legislatures to severely constrict and then eliminate midwifery” as older generations of midwives were increasingly unable to replace their ranks represented “the most significant negative measure.” See Warsh, *Prescribed Norms*, p. 94 and Mitchinson, *Giving Birth in Canada*, pp. 72-77.

experienced) midwife. When the midwife dipped the end of a goose quill in cayenne pepper, Bigelow “wondered what the devil was coming next”:

She took the quill and inserted it into the nostril of the patient, then gave it one big blow, and away went the cayenne pepper into the poor woman’s nasal cavity. I knew what was liable to happen. She began to sneeze immediately. With the sneezing the midwife said, ‘Doc, you’d better get ready’. By the time I had taken a look at things, the perineum was bulging, and with another few sneezes the baby was born.

Bigelow commented he had “never forgotten this way of conducting a quick labor.”<sup>165</sup>

Bigelow’s tolerance for the midwife’s less than orthodox methods was likely grounded on his previous positive experiences working with midwives as part of his rural practice. He fondly remembered two “wonderful women” he first encountered when attending an eclampsia case in Hartney, Manitoba in December 1904. Though he and his colleagues referred to the women as “gamps,” Bigelow recalled that the women were well-versed in conducting deliveries according to the principles of antisepsis.<sup>166</sup> Writing in the 1960s, he concluded that “it would take a lot of nurses these days to do what those women could do in their practical way.”<sup>167</sup> The relationship appears to have been mutually beneficial. After successfully seeing his eclampsia patient through her delivery, Bigelow was entrusted with the bulk of maternity work in Hartney, and recounted that “my practice in that town and that district was assured. The ‘gamps’ were great boosters

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<sup>165</sup> Bigelow, *Forceps, Fin, and Feather*, p. 52.

<sup>166</sup> For more on the gendered construction of midwives’ professional identity, see Heather Stanley, “Sairey Gamps, Feminine Nurses and Greedy Monopolists: Discourses of Gender and Professional Identity in the *Lancet* and the *British Medical Journal*, 1886-1902,” *Canadian Bulletin of Medical History* 29, no. 1 (2012), pp. 49-68.

<sup>167</sup> Bigelow, *Forceps, Fin, and Feather*, p. 53.

of mine for the next two years of my practice there.”<sup>168</sup> In his memoirs, Archibald D. Campbell also emphasized the positive presence of a midwife in his home community of Glencoe, Ontario. Describing Mrs. Effie Ferguson, a “Scotch widow,” as a “midwife, general nurse, and tower of strength within any emergency,” Campbell praised her “clinical sense” and “immaculate” habits in the birthing room.<sup>169</sup>

Other doctors were dismayed by midwives’ techniques. Samuel Peikoff, attending a difficult case while practicing in rural Manitoba in the late 1920s, remembered arriving at a confinement where a “middle-wife” from “the old country” presided over the birthing room. Horrified by the midwife’s use of “fresh cow manure” to lubricate the birth canal as a means of easing delivery, he ultimately concluded that the birthing room “was not the time or the place for a confrontation,” adding that any discussion would be complicated by the fact that “midwives resented doctors with their ‘fancy ideas’ because they were jealous.”<sup>170</sup> Peikoff contrasted this experience with the “meticulous” techniques of “trained” nurses he had encountered in the obstetrical ward at Edmonton’s Royal Alexandra Hospital a few years earlier.

Despite the positive experiences of some physicians, professional distinctions between midwives and physicians continued to be articulated. Even in Great Britain, where the Midwives Act of 1902 made provisions for the formal training and certification of this category of practitioners, the most ardent supporters of midwifery were careful to

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<sup>168</sup> Bigelow, *Forceps, Fin, and Feather*, p. 54.

<sup>169</sup> Praising Ferguson’s ability to conform to accepted standards in obstetric practice, Campbell recounted that her conduct in the birthing room “indeed embodied the principles [of antiseptics] enunciated by Oliver Wendell Holmes [sic] and later demonstrated by Semmelweis.” Campbell, *Autobiography*, pp. A7-A8, A72-A74.

<sup>170</sup> Peikoff practiced in Rosburn, a village of approximately 700, where roughly 75% of the population was of Ukrainian descent. Peikoff, *Yesterday’s Doctor*, p. 31.

point out that “midwives [were] not ‘medical practitioners’ in the technical sense.”<sup>171</sup>

Concerns surrounding the “ignorant” practices of midwives continued, on the part of many physicians, well into the interwar period.<sup>172</sup> At the same time, however, Canadian practitioners increasingly recognized that midwives possessed “various degrees of training,” and emphasized the “crying need” for specially-trained assistants in the birthing room.<sup>173</sup>

Physicians also recalled a variety of experiences in working with nurses throughout this period. Remembering his early days as a practitioner in Southwestern Ontario, William Victor Johnston noted that he learned early on that “nurses were the doctor’s best friends – both practical and registered nurses, including midwives.” Writing that his community “had a reasonably adequate supply of what were called practical nurses, mostly middle-aged women without formal training but with a natural aptitude for caring for the sick,” Johnston asserted that such women were “understandably...in constant demand.”<sup>174</sup> Peikoff also recalled working with “two young farm girls trained as practical nurses” during the 1920s and 1930s.<sup>175</sup>

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<sup>171</sup> Sir Frances Champneys, the first Chairman of the Central Midwives Board and a key figure in the passage of the Midwives Act, made this point in an 1895 address to the British Obstetrical Society. Sir Frances Champneys, *Centenary of Birth, Autobiography and Biographical Sketches*, Sir Weldon Dalrymple-Champneys Collection, GC/139/C.3, Wellcome Library.

<sup>172</sup> Williams warned students in 1931, for example, that the use of ergot in cases of prolonged labour was something associated only with the practices of “ignorant midwives.” Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 820.

<sup>173</sup> A 1929 article in the *CMAJ* emphasized the “crying need for specially trained obstetric nurses, call them midwives if you will.” H.M. Little, “What’s the Matter with Obstetrics?” *CMAJ* 20, no. 6 (June 1929), p. 647. See also Phair, “Maternal Mortality – A General Survey,” p. 179.

<sup>174</sup> Johnston, *Before the Age of Miracles*, p. 44.

<sup>175</sup> Peikoff, *Yesterday’s Doctor*, p. 66.

By the first decades of the twentieth century, many Canadian nurses, like their physician counterparts, placed increasing emphasis on the formal and scientific training they received, seeking to distance themselves and their work from their “untrained” colleagues.<sup>176</sup> Obstetricians often praised the assistance that these formally-trained women, often affiliated with the Victorian Order of Nurses (established in 1897) had to offer during their confinement cases.<sup>177</sup> Wilfrid Abram Bigelow recalled meeting his wife, Nurse Grace Anne Carnegie Gordon, at Christmas 1904, when she assisted him on one of his first maternity cases in Hartney. Gordon, who was trained in England and in town visiting her parents, was charged with keeping the parturient patient quiet, “holding her back with small doses of codeine until I arrived at 4:30pm and the baby was born about six.”<sup>178</sup> Likewise, Peikoff reserved his highest praise for Miss Steward, the department supervisor at Edmonton’s Royal Alexandra Hospital who had effectively introduced him to obstetrics in the early 1920s.<sup>179</sup> Other physicians denigrated the abilities of nurses, particularly when they were involved with their training. Oswald Withrow, who received his M.D. from the University of Toronto in 1902 and went on to practice throughout Ontario, recorded a feeling of dread at the prospect of lecturing to a

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<sup>176</sup> The first training program for nurses in Canada was established in 1874. See Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996).

<sup>177</sup> In the early twentieth century, obstetrical cases made up “a very large proportion of the work undertaken by the Victorian Order throughout Canada.” Elizabeth Smellie, “Maternity Service of the Victorian Order of Nurses for Ontario,” *CJMS* 66, no. 2 (August 1929), p. 45.

<sup>178</sup> Bigelow continued, “there followed six months’ courtship in which she nursed my cases as often as I could possibly arrange it.” Bigelow, *Forceps, Fin, & Feather*, p. 10.

<sup>179</sup> Peikoff, *Yesterday’s Doctor*, p. 6.

class of nurses in Fort William in January 1909, lamenting that he “could not help wishing that they knew a little more about things. One has to make things so simple.”<sup>180</sup>

Despite opinions like Withrow’s, the majority of physicians appear to have appreciated, to some extent, the services proffered by trained nurses. They took care to set up and reinforce hierarchies within the nursing profession. In his 1904 text, *Obstetrics for Nurses*, Joseph B. DeLee asserted that for both physician and patient alike, the choice of a “monthly nurse” or “a woman that has nursed in many cases” was no substitute for the assistance of the trained “obstetric nurse.”<sup>181</sup> Henry Jellett, in his 1910 volume, also distinguished between more traditional nurses and those trained in modern and scientific nursing techniques, drawing negative attention to the habits of “the older nurses, who considered that it was part of their duty to follow the entire labour with the finger in the vagina to assist in the dilation of the os.” Jellett lamented that the physician’s difficulty in preventing the untrained nurse from practicing such techniques “was considerable.”<sup>182</sup> Fairbairn also emphasized the significance, for both doctor and patient, of choosing the “right nurse” to provide assistance during confinement, arguing that “the talkative and ignorant creature who scares her patients with stories of what has happened to other unfortunate mothers on whom she has been inflicted, and the nervous woman, who is

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<sup>180</sup> O.C.J. Withrow, Diary, 15 January 1909, Dr. O.C.J. Withrow Papers, F 1375, MU 7540, Archives of Ontario.

<sup>181</sup> Joseph B. DeLee, *Obstetrics for Nurses*, First Edition (Philadelphia: W.B. Saunders Co., 1904), p. 164. For more on these hierarchies see Judith Young, “‘Monthly’ Nurses, ‘Sick’ Nurses, and Midwives in 19<sup>th</sup>-Century Toronto, 1830-1891,” *Canadian Bulletin of Medical History* 21, no. 2 (2004), pp. 281-302.

<sup>182</sup> Jellett, *A Manual of Midwifery*, p. 340.

easily worried by any incident she thinks may indicate something abnormal, are especially to be avoided.”<sup>183</sup>

Physicians also aimed to establish and perpetuate clear professional hierarchies between doctors and nurses. Textbooks for nurses, including DeLee’s *Obstetrics for Nurses* (1904) and Joseph Brown Cooke’s *A Nurse’s Handbook of Obstetrics* (1907) tended to be shorter than virtually all of the leading obstetric texts of the period, regularly coming in at half the length of many physician-directed volumes.<sup>184</sup> Written to prevent the nurse from being “obliged to turn for her information to books written solely for the use of physicians and medical students, and filled with incomprehensible technicalities and confusing statistics and discussions,” the ways in which nursing texts were framed reinforced the distinction between physicians and other medical practitioners.<sup>185</sup> Within such volumes, physician-authors also noted that they made frequent and intentional repetitions in order to make things “perfectly clear to the beginner in the study of nursing.”<sup>186</sup> Well into the twentieth century (and, to a large extent, even today) these professional hierarchies were emphasized, with physicians alone portrayed as having the power to interpret medical data or information and diagnose or treat patients. In their 1946 text, Archibald D. Campbell, then Associate Professor of Obstetrics and

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<sup>183</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 345.

<sup>184</sup> These two volumes were 400 and 490 pages, respectively, compared to many volumes for medical students, which regularly clocked in at over 1000 pages.

<sup>185</sup> Joseph Brown Cooke, *A Nurse’s Handbook of Obstetrics: For Use in Training Schools* (Philadelphia and London: J.P. Lippincott, 1907), p. 7. This text was published in at least eight editions.

<sup>186</sup> Cooke, *A Nurse’s Handbook of Obstetrics*, p. 8. On some occasion, doctor/nurse professional divides were blurred. In his 1904 text, DeLee stated that although the volume was intended primarily for nurses, he believed that “medical students will find something of value in it, since the duties of a nurse often devolve upon them in their early years of obstetric practice.” DeLee, *Obstetrics for Nurses*, p. 9.



Gynaecology at McGill University, and Mabel A. Shannon, Supervisor of the Gynaecological Ward at Montreal General Hospital, advised student nurses to “make accurate and liberal bedside notes,” in the hopes that the physician would be “able to glean valuable information” that would aid in diagnosis and treatment.<sup>187</sup>

Despite the fact that nurses were consistently and explicitly differentiated from physicians, and the fact that physicians claimed that their expertise uniquely qualified them to provide modern, scientific care to their obstetric patients, nurses were, at times, called on to perform duties beyond the scope of their perceived professional role. In these circumstances, however, specialists in obstetrics were careful to advise future practitioners – both nurses and doctors alike – of the physician’s ongoing control in the birthing room. In his nursing text, DeLee admitted that “the nurse occasionally has to administer the anaesthetic.” He advised all parties involved that it should always be “understood that the physician assumes the responsibility.” DeLee argued that “it is best, in such cases (which, in the writer’s opinion, should not occur), for the physician to put the patient asleep and let the nurse continue the narcosis,” though “in justice to all concerned a [separate] anesthetizer ought to be employed.”<sup>188</sup> On his part, while he suggested to nurse-trainees that, “in normal cases, the duty of administering the anaesthetic usually falls to the nurse,” Cooke qualified that “the nurse should not be expected to shoulder the responsibility of administering the chloroform” in operative cases when a second physician should be called in to act as anaesthetist. Nurses were

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<sup>187</sup> Campbell and Shannon, *Gynecology for Nurses*, v. McPherson argues that Canadian nurses “could not generate scientific knowledge because they were legally barred from doing so.” McPherson, *Bedside Matters*, p. 112.

<sup>188</sup> DeLee, *Obstetrics for Nurses*, p. 173.

advised, at the first sign of doubt as to the condition of the patient, to “call upon the physician for assistance or advice without delay.”<sup>189</sup>

Lessons and texts directed at Canadian medical students placed greater emphasis on the risks associated with nurse-administered anaesthesia. Asserting that “surgeons generally observe a good rule in making the administration of anaesthetics the work of one man who shall assume full responsibility” and arguing that “obstetricians would do well to adopt the same rule, which is really the only safe one,” Adam Wright singled out the “many practitioners” who allowed the nurse to administer anaesthesia to the obstetric patient. He suggested that although such physicians “direct the nurse and watch the patient as closely as possible,” the practice involved a “considerable” amount of unnecessary risk.<sup>190</sup> English physicians Comyns Berkeley and Victor Bonney agreed in their 1921 text, but pointed out that “the practice of the obstetrician himself anaesthetizing the patient is a bad compromise.”<sup>191</sup> While future practitioners were advised that the best way to proceed in cases requiring heavy anaesthetization (as opposed to analgesia) was to secure the services of a third physician, medical students and young physicians often recalled a host of difficulties in finding appropriate assistance, even from their fellow medical professionals.<sup>192</sup>

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<sup>189</sup> Cooke, *A Nurse's Handbook of Obstetrics*, pp. 158-160, 165.

<sup>190</sup> Wright, *A Text-Book of Obstetrics*, pp. 557-558.

<sup>191</sup> Berkeley and Bonney argued that this scenario made it impossible for the physician to “render the patient insensible” while performing any deliveries or procedures with “the maintenance of surgical asepsis and freedom from hurry in his manipulations.” Comyns Berkeley and Victor Bonney, *The Difficulties and Emergencies of Obstetric Practice* (Toronto: The MacMillan Company of Canada Ltd, 1921), p. 570.

<sup>192</sup> Alexander described calling on a Dr. Freeman, who did an excellent job in administering ether anesthesia, provided he was called the night before the confinement – “if he happened to come down in the afternoon, his ability to give the anaesthetic, maybe it would be impaired.” Likewise, Peikoff remembered one case in which the town druggist, who boasted of his experience in giving

By the opening decades of the twentieth century, physicians were agreed that greater expertise in anaesthesia was sorely needed. Though Wright, in 1908, had proclaimed the need for “a positive rule” amongst practitioners to ensure that parturient patients were anaesthetized by “an expert anaesthetist, or at least a licensed practitioner,” the anaesthetization of birthing women by untrained practitioners continued well into the interwar period, particularly in rural areas.<sup>193</sup> In the opening address of the 1927 Annual Meeting for the Canadian Society of Anaesthetists, taking place at the University of Toronto, society Chairman Harry James Shields stressed the ongoing importance of specialization in anaesthesia.<sup>194</sup> Discussions about the amount of specialization required, however, appear to have continued over the next decade.<sup>195</sup>

## Conclusion

Despite the ongoing shortcomings of obstetric education and the paucity of trained professionals to offer anaesthesia to their parturient patients, the majority of late

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“dozens of anaesthetics” for senior physicians, got drunk on home brew with the husband of the parturient patient. Despite this complication, Peikoff asserted that it was his experiences working with the senior Dr. Ekels, who was “just not trained” in the proper administration of anaesthesia, that resulted in “tense moments of struggle” and “pockmarked scars on [his] heart.” Both of these cases took place in the 1920s. Alexander, *56 Years of Medical Practice*, p. 25, and Peikoff, *Yesterday’s Doctor*, pp. 28-34, 66-67.

<sup>193</sup> Wright, *A Text-Book of Obstetrics*, p. 144. Bigelow recalled a “real emergency” while practicing in Souris, MB, that required a sixteen year old girl, working in the house as hired help, to administer chloroform anaesthesia during a high-forceps operation. Bigelow, *Forceps, Fin, and Feather*, p. 58.

<sup>194</sup> Minutes, Canadian Medical Association, Section on Anaesthesia, 1927-1955, Canadian Medical Association Fonds, Medical Sections, MG 28 I 343, Volume 5, Library and Archives Canada. Shields established the first residency program in Anaesthesia at the University of Toronto.

<sup>195</sup> At the 1937 Annual Meeting in Ottawa, society members disagreed with the Canadian Medical Association’s recommendation that “two years specialization in anaesthesia” be required for specialist certification,” with the opinion of the meeting being “that this was too long, especially for a man going into a small town. Minutes, Meeting of the Section of Anaesthesia, combined with The Canadian Society of Anaesthetists, 23 June 1937, Canadian Medical Association Fonds.

nineteenth and early twentieth century practitioners seemed to agree on a set of core professional lessons. Adherence to these dicta, physicians held, would enable the young doctor to articulate his expertise relative to both his patients, and other figures who may have been present in the birthing room, including family members, midwives, and, increasingly, nurses. In this way, these medical men established and continued to exert a considerable degree of control over the deliveries of their patients, well before hospital birth became the norm in many areas of Canada in the mid-twentieth century.

While there was a sense of consensus on these professional issues, along with, by the first decades of the twentieth century, the basic principles of anatomy and surgery, Canadian physicians were still prone to debate. In both medical texts and the professional periodical literature, both general practitioners and those who saw themselves as specialists in the emerging field of obstetrics routinely highlighted the pathological or disease-like condition of the female body, pregnancy, and childbirth. The most popular texts of the period were routinely divided into core sections emphasizing the “Pathology of Pregnancy”, the “Pathology of Labour”, and the “Diseases of Childbed.” They included lengthy instructions to the young practitioner on the need to properly “diagnose” both pregnancy and the onset of parturition based on a variety of vague and specific “symptoms” that would lead the knowledgeable professional to such conclusions.<sup>196</sup> This process of pathologization, increasingly accepted and fuelled by the majority of mainstream Canadian medical practitioners, continued well into the twentieth century alongside the broader professionalization of obstetrics.<sup>197</sup> Where Canadian physicians

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<sup>196</sup> See Lusk, *The Science and Art of Midwifery* and Wright, *A Text-Book of Obstetrics*, p. 92.

<sup>197</sup> Wolf has argued that “despite the fact that...the vast majority of births result in healthy outcomes without medical interventions, obstetrics did not join the fold of respected medical

continued to disagree, however, was in articulating the best ways to approach the pathologized bodies and births of their expectant female patients, particularly when it came to managing the ever-present, and seemingly increasing, pains of parturition.

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specialties until obstetricians wholeheartedly embraced assorted medical technologies.”  
Jacqueline Wolf, “‘Mighty Glad to Gasp in the Gas’: Perceptions of Pain and the Traditional Timing of Obstetric Anaesthesia,” *Health* 6 (2002), p. 381.

## **Chapter 2**

### **“The Normal Merges into The Abnormal, The Healthy into Disease”:**

#### **Conceptualizing Women’s Bodies and Births in Professional Medical Discourses**

Well into the first decades of the twentieth century, Canadian physicians continued, in large numbers, to graduate from medical school lacking firsthand experience in obstetrics. In this atmosphere, professional publications, including medical texts and periodicals, played an especially significant role in shaping practitioners’ views of the female body, pregnancy, and birth. While we may assume that such sources, based on scientific and medical “facts”, offer an objective analysis of these bodily states, such medical narratives and texts constructed women’s bodies, births, and pains in a particular way that was inseparable from the broader social tensions and cultural anxieties of the late nineteenth and early twentieth centuries.

While the dominant medical rhetoric of the period emphasized increasingly pathological views of all bodies and births, mainstream medical discourses routinely and simultaneously pathologized and privileged a certain set of female patients – those who could be classified as white, intelligent, educated, and refined, hailing, most often, from the well-to-do classes and urban areas. The majority of practitioners continued to decry unnecessary interference and “meddlesome midwifery,” particularly in textbooks. They simultaneously emphasized, however, that these white, middle and upper-class bodies – belonging to the women who made up the bulk of their patients – required heightened levels of expert attention, guidance, and care (including, for many women, instrumental or operative interference) to make it safely through the tumultuous periods of pregnancy and birth.

## The Professional Periodical Press in Late Nineteenth and Early Twentieth Century Canada

Though the majority of medical texts devoted to obstetrics published in the late nineteenth and early twentieth centuries were written by emerging or established specialists in the field, the broad range of medical periodicals published in Canada throughout this period incorporated an equally broad range of voices from physicians practicing across the country and internationally. Wendy Mitchinson has argued that, unlike textbooks, Canadian journals “allowed the average practitioner to have his say,” with physicians from rural and small-town settings writing to describe their theories and practices with remarkable regularity.<sup>1</sup> Like the majority of reference works published at the turn of the twentieth century, journals tended to privilege the viewpoints of “the urban medical elite” – those practitioners affiliated with teaching hospitals who often dominated the editorial boards of medical periodicals and were also most likely to be the authors of Canadian textbooks.<sup>2</sup> Nevertheless, these sources offer a diverse view of both the leading medical opinions and debates throughout this period.

In addition to publishing traditional research articles, Canadian medical periodicals offered reviews of the latest research being published both nationally and internationally in book and article form, reprints of public lectures, summaries and commentary on matters discussed at provincial, national, and international medical

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<sup>1</sup> Mitchinson, *Giving Birth in Canada*, p. 16.

<sup>2</sup> Toronto physician Adam Wright, for example, the author of the popular *A Text-Book of Obstetrics* (1908), was one of the original editors of the *Canadian Practitioner and Review*, in addition to being elected president of the Ontario and Canadian Medical Associations in 1900 and 1909, respectively. Quote from Mitchinson, *Giving Birth in Canada*, p. 16. See also Mitchinson, *Body Failure*, p. 293.

conferences and meetings, and editorials offering an “expert” medical perspective on a host of health and social issues. These sources, then, represent the predominant site of medical debate throughout this period, while simultaneously providing a record of other medical discussions taking place amongst practitioners. Journals also offered valuable descriptions of individual cases, presented by physicians practicing medicine from a variety of different perspectives and backgrounds. These individual case studies, when examined alongside the lessons presented in many of the texts discussed in the previous chapter, provide valuable evidence of the ongoing disconnect between “what some practitioners were doing” and “what they were taught to do.”<sup>3</sup>

Over 100 medical journals were published during the period under study.<sup>4</sup> The length of individual print runs varied greatly, particularly during the nineteenth century.<sup>5</sup> Many journals, including major national publications, also underwent frequent title changes. The *Public Health Journal (PHJ)*, for example, originally published in 1910, became the *Canadian Journal of Public Health (CJPH)* in 1929, and the *Canadian Public Health Journal (CPHJ)* in 1943. While it is difficult to discern the impact of individual publications, it is clear that the research and discussions published in the most influential of these volumes – most notably the *Canadian Medical Association Journal (CMAJ)*, established in 1911 – had the potential to reach a wide audience of medical professionals, both within Canada and internationally. In the absence of other sources of

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<sup>3</sup> Mitchinson, *Giving Birth in Canada*, p. 16.

<sup>4</sup> See Charles G. Roland and Paul Potter, *An Annotated Bibliography of Canadian Medical Periodicals, 1826-1975* (Toronto: Hannah Institute for the History of Medicine, 1979).

<sup>5</sup> Charles Roland has highlighted the short-lived nature of many of these publications. Charles G. Roland, “Ontario Medical Periodicals as Mirrors of Change,” *Ontario History* 72, no. 1 (March 1980), pp. 3-15.



information, the messages these periodicals contained had great potential to shape medical views of the nature of the female body, pregnancy, and birth.

Just as the leading obstetric texts of the day were often written by non-Canadian authors and published by non-Canadian presses, the Canadian medical periodical literature also represented a strong sense of communication between international practitioners and cross-fertilization of medical theories and practices. The majority of the leading Canadian journals routinely included articles – both original contributions and reprints – written by British, and increasingly, American authors, and Canadian periodicals regularly offered synopses and commentary on the international medical literature, well into the twentieth century.<sup>6</sup> Routinely presented without comment or distinction alongside contributions from Canadian authors, this non-Canadian content formed an important part of both periodicals and the broader context of Canadian medical practice. To ignore such content, as Mitchinson has argued, would offer an incomplete picture of “the world Canadian physicians inhabited.”<sup>7</sup>

Despite this internationalism, editors emphasized Canadian contributions, highlighted Canadian discussions, and framed their journals as the “organ and representative of the medical profession in Canada.” Canadian physicians were urged to publish the results of all their “important cases, be they successful or the reverse.”<sup>8</sup>

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<sup>6</sup> An October 1930 article published in the *CMAJ*, for example, offered a survey on attitudes towards anaesthesia during childbirth, commenting on both Canadian attitudes, and those represented “among the many papers which have appeared recently in both the British and American medical press.” A.D.B., “Anaesthesia During Childbirth,” *CMAJ* 23, no. 4 (October 1930), p. 564.

<sup>7</sup> Mitchinson, *Body Failure*, p. 294.

<sup>8</sup> “Canada Medical Journal,” *Canada Medical Journal and Monthly Record of Medical and Surgical Science (CMJ)* 1, no. 1 (July 1864), p. 42.

Regardless of this encouragement, however, it is impossible to discern how forthcoming individual practitioners might have been when it came to reporting the results of their less successful cases, experiments, and methods. Canadian practitioners, including Herbert M. Little, Assistant Professor in Obstetrics at McGill University, writing in the early 1910s, appear to have recognized physicians' potential reluctance to disclose mediocre or discouraging results, but argued, nonetheless, that "records of failures, though less frequently reported than those of successes, [were] perhaps more instructive."<sup>9</sup> In the majority of articles, physician-authors tended to focus on "exceptional" cases, and this emphasis had a definite impact on moulding medical views of the female body, pregnancy, and birth throughout the period under study. While medical textbooks tended to present the normal or "typical" obstetric case – though they went on to highlight the many problems or complications that often arose in the birthing room – physicians relied on the periodical literature to showcase "the unusual case rather than the usual."<sup>10</sup> In both textbooks and journal articles, Canadian practitioners articulated and were exposed to viewpoints that emphasized increasingly pathological views of pregnancy and birth, casting the healthy female body as an outlier or aberration.<sup>11</sup>

### Bodies In Decline: The Pathologization of the Female Body

By the closing decades of the nineteenth century, medical experts throughout the western world increasingly emphasized the ill-effects that modernity had on the body. As

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<sup>9</sup> Herbert M. Little, "On Death and Disability Resulting from Childbirth," *CMAJ* 1, no. 2 (February 1911), p. 125.

<sup>10</sup> Mitchinson, *Giving Birth in Canada*, p. 16.

<sup>11</sup> Mitchinson, *Body Failure*, p. 294.

with many other medical debates during this period, Canadian physicians both participated in and echoed this rhetoric. They argued that the bodies of all Canadians were subject to the pressures of civilization, defined by Montreal physician A. Lapthorn Smith in an 1889 article in the *Canada Medical Record (CMR)* as “the ensemble of social customs, habits, refinements of manners, comforts, and luxuries which are not practiced or enjoyed by human beings in the savage state.”<sup>12</sup> Doctors and other medical professionals remained concerned about the adverse effects associated with the pace of modern life well into the twentieth century. An underlying theme of antimodernism and an often not so subtle emphasis on the tensions implicit in modernity suffused their discussions of the changing condition of the human body.

In 1907, Dr. A.B. Atherton argued in the *Canada Lancet (CL)* that urban overcrowding and “the insufficiency of fresh air which necessarily follows” contributed, in every “civilized nation,” to widespread deterioration in both “general physique” and “mental powers.”<sup>13</sup> Physicians argued that modern life had an adverse impact on the bodies of all Canadians, regardless of gender, class, or race. A 1911 examination of “Social Problems in Relation to Medicine,” published in the *CMAJ* concluded that the “abnormal daily existence” of “the ordinary urban worker of to-day,” shaped around “the early morning whistle of the factory,” and an “evening screech” to send him home to “absolutely squalid conditions,” weakened the bodies of these men, particularly when compared to their “primitive” counterparts who spent their lives enjoying “sunshine,

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<sup>12</sup> A. Lapthorn Smith, “What Civilization is Doing for the Human Female,” *Canada Medical Record (CMR)* 18, no. 2 (November 1889), p. 25.

<sup>13</sup> A.B. Atherton, “The Causes of the Degeneracy of the Human Race,” *Canada Lancet (CL)* 41, no. 2 (October 1907), p. 97.

fresh air, and good food.”<sup>14</sup> Concerns surrounding the ongoing effects of industrialization on the bodies of Canadian workers intensified in the years following the First World War, with medical professionals weighing in, often at length, on the ill effects that modern labour conditions had on the “sensitive” and “delicate” condition of “the human machine,” increasingly framed as the backbone of both the economy and the nation.<sup>15</sup>

As a logical accompaniment to emphases on the health of the worker, medical experts argued for the ongoing need to protect the health of families, and especially mothers, by ensuring good “working conditions” in the home: “the first factory of the nation.”<sup>16</sup> This was especially the case after World War I, as all Canadians felt the effects of the tremendous losses of life associated with both the conflict and the subsequent 1918-1919 influenza epidemic, two events directly contributing to the establishment of the Federal Department of Health in 1919. A 1924 editorial in the *CJMS* cited the habits of modern life – “too much rapid work; too much food, too rapidly eaten; too much tobacco; too much hustle and bustle; too much sexual intercourse (to be quite frank); too little sleep; too many irons in the fire” – as key factors contributing to the high and increasing rates of degenerative diseases experienced by middle-aged Canadians.<sup>17</sup> Emphasis on this process of “racial decay” continued throughout the interwar period,

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<sup>14</sup> Richard Monahan, “Social Problems in Relation to Medicine,” *CMAJ* 1, no. 4 (April 1911), p. 338.

<sup>15</sup> In an April 1920 address, J.W.S. McCullough, Chief Officer of Health for the Province of Ontario argued that “both from the standpoint of humanity and the standpoint of economy the human machine deserves greater care and consideration than any other mechanism engaged in the production of wealth.” J.W.S. McCullough, “Industrial Hygiene,” *PHJ* 9, no. 6 (June 1920), pp. 244-245.

<sup>16</sup> “The Home – The First Factory of the Nation,” *PHJ* 16, no. 11 (November 1925), pp. 524-529.

<sup>17</sup> “Editorial: The Pace that Kills,” *CJMS* 56, no. 3 (September 1924), p. 74.

with a 1927 article in the *CMAJ* concluding that the rapid physical changes continuing to effect the bodies of men and women alike were “mainly degenerative.”<sup>18</sup>

These pressures, though adversely impacting the health of all Canadians, were long thought to have a particular and significant effect on the health of Canadian women. Lapthorn Smith argued that the “altered circumstances” associated with civilization, which saw the woman gradually exchange “her life in the open air for close confinement in the house,” exacerbated individual susceptibilities to some of the many diseases experienced by this half of the population.<sup>19</sup> These factors contributed to pathological differences in the female body that were thought, by physicians, to vary depending on the mode of living and race of the woman in question. For all female bodies, however, weakness and delicacy was seen to begin at the skeletal level.

Feminist historian of science Londa Schiebinger has argued that early anatomical representations of the female skeleton, first appearing in eighteenth century Europe, highlighted those parts of the body that were thought to be of particular social and political significance. Anatomical emphases on the female pelvis, larger than that of the male, provided “scientific” evidence that was used by many medical practitioners and social commentators “to prove that women were naturally destined for motherhood, the confined sphere of hearth and home.”<sup>20</sup> In a process that continued into the first half of the twentieth century (and, to some extent, continues, even today), these physical

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<sup>18</sup> “On Racial Decadence,” *CMAJ* (March 1927), pp. 341-342.

<sup>19</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), p. 25.

<sup>20</sup> Londa Schiebinger, “Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy,” in *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century*, eds. Catherine Gallagher and Thomas Laqueur (Berkeley: University of California Press, 1987), pp. 42-82. Quote on p. 43.

differences were used to prescribe and reinforce different gender roles for men and women. This gendered hierarchy, Schiebinger argues, was further secured by the discovery of other anatomical similarities – most notably, the underdevelopment or “incomplete growth” of the rest of the body relative to the size of the skull – between the bodies of women, and those of children and so-called “primitives.” This evidence was used to support the assertion that women occupied a lower rung in the evolutionary hierarchy, particularly when compared with white men.<sup>21</sup>

This emphasis on the physiological distinctions between male and female bodies continued into the late nineteenth and early twentieth centuries, with these differences routinely articulated by Canadian physicians throughout this period. In lessons that emphasized the sensitive, gentle, and delicate nature of the female body at the most basic level, Canadian medical students and future practitioners were consistently instructed that women’s pelvises were “proportionately larger, but of a more delicate construction” than those of their male counterparts.<sup>22</sup> Bolstered by late-Victorian evolutionary rhetoric, Smith argued that according to the law of survival of the fittest, the woman with a pelvis too narrow to safely bear a child, would, if left to nature, “probably perish in her first confinement, so that that breed of women would at once die out.” Smith surmised that, unfortunately, medical intervention ensured that the bodies and lives of these women were “preserved to give birth to many children of which some will be females with pelvises even smaller than their mothers.” He recommended that for such women, the removal of the uterus, now a safe possibility due to the same medical advancements that

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<sup>21</sup> Schiebinger, “Skeletons in the Closet,” p. 46, 63. See also Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge: Harvard University Press, 1990).

<sup>22</sup> Hirst, *A Text-Book of Obstetrics*, p. 19.

prevented these women from dying in the birthing room, “would put a stop to such vicious breeding.”<sup>23</sup> Aside from evolutionary degeneration, experts in the emerging field of obstetrics held that the pelves of individual women could be negatively affected in both size and shape due to the “errors of development” that routinely accompanied the lifestyles of the most wealthy and poorest members of society, with rates of pelvic contraction being much higher “in larger cities than in rural districts”<sup>24</sup> Mainstream medical rhetoric, then, held that the pelvis was not immune to the same degenerative influences that had the potential to affect the rest of the body. Instead, medical discourse suggested that an examination of the pelvis could be used to interpret overall bodily health, with the pelves of different groups of women held up as evidence of the relative strength (or lack thereof) of those types of bodies.<sup>25</sup>

The most significant pelvic discrepancies were consistently attributed to perceived racial differences. Well into the twentieth century, medical rhetoric held that “considerable variations” could be observed in comparing “the form of the pelvis in various races, and especially upon comparing those obtained from Aboriginal and civilized people,” with the pelvis becoming “increasingly lower and broader the more civilized the race from which it is obtained.”<sup>26</sup> Students were routinely taught, according to one 1931 text, that “with the exception of the skull, no portion of the skeleton presents

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<sup>23</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), p. 28.

<sup>24</sup> Eden, *A Manual of Midwifery*, pp. 394-395.

<sup>25</sup> Christopher Forth and Ivan Crozier argue that the idea that bodily equilibrium was necessary for overall health often relies on the direct or indirect emphasis on “the significance of certain parts in the bodily economy, sketching their dominance over the rest of the body’s organs.” Christopher E. Forth and Ivan Crozier, “Introduction: Parts, Wholes, and People,” in *Body Parts: Critical Explorations of Corporeality*, eds. Christopher E. Forth and Ivan Crozier (New York: Lexington Books, 2005), p. 6.

<sup>26</sup> Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, pp. 15-16.

greater individual variations than the pelvis.” This part of the body, then, as John Hoberman has argued, became a signifier of racial, ethnic, and gender difference.<sup>27</sup> These deeply underscored differences between various female bodies, in turn, strongly suggested that women would face different experiences in pregnancy and birth, depending on these categories – a point that will be discussed later in this chapter.

By the turn of the twentieth century, this emphasis on the ongoing cycle of racial degeneration and decline, exacerbated by the pressures of modern life, led some Canadian practitioners to argue that certain female bodies were irrevocably weakened from the moment of birth. Smith, for example, one of the most vocal proponents of this rhetoric, argued in 1889 that while “in the savage state the female child is born with equal chances with the male... the daughter of civilization, on the contrary, inherits at her birth the diminished lung capacity and breathing power of her highly educated mother.”<sup>28</sup> Amongst the so-called fashionable classes, these deficits continued to be exacerbated by late-Victorian childrearing practices. In arguments that drew heavily on the imagery associated with the Victorian “angel in the house” that were most prevalent in the years before the First World War, medical experts suggested that the “modes of living” that set certain women – specifically those well-to-do, urban-dwelling women who could be classified as white – up for a lifetime of delicacy, degeneration, and decline, were established early on in the life cycle.<sup>29</sup> Young girls, unlike their brothers, were set on a

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<sup>27</sup> Williams, *Obstetrics; A Textbook for the Use of Students and Practitioners*, p. 12. John Hoberman, “The Primitive Pelvis: The Role of Racial Folklore in Obstetrics and Gynaecology During the Twentieth Century,” in *Body Parts: Critical Explorations in Corporeality*, eds. Christopher E. Forth and Ivan Crozier (New York: Lexington Books, 2005).

<sup>28</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), p. 25.

<sup>29</sup> Mitchinson has argued that “the years before the war were very much influenced by Victorian perceptions of women, albeit with the recognition that significant changes in many women’s lives had taken place.” Mitchinson, *Body Failure*, p. 3.



particular path towards ill health. One 1907 text argued that compared to her male counterpart, the young girl was routinely, and wrongly

denied the health giving pleasures of the rougher sports. Her brother comes in from his play with glowing cheeks and a ravenous appetite, and when he seeks his couch it is to fall into a deep and refreshing sleep. She spends most of her time within four walls, and is done up in stays and tight-fitting clothes, has little in the way of recreation, and that is of the tamest sort, and to cap the climax is placed under tutorage at a tender age and is expected to compete with her brother in mental attainment. And what is the result? Simply that which might be expected: a frail and delicate body, a high-strung and unstable nervous organization, and a hot-house brain. She has been reared and educated for invalidism, incapacity, and life-long suffering.<sup>30</sup>

Canadian physicians overwhelmingly agreed that when these unnatural habits continued into adolescence, the results could be disastrous.

The years surrounding menarche were consistently depicted in Canadian medical discourses as a crucial developmental period – one during which women faced the potential of becoming “heavily handicapped” by a variety of health complaints.<sup>31</sup>

Echoing other doctors who relied on mechanistic metaphors in their descriptions of the human body, Winnipeg physician J.N. Hutchinson, describing the development of female bodies during adolescence at the 1901 Annual Meeting of the Canadian Medical Association, argued that “if the reproductive machinery is not manufactured at this period it will never be.”<sup>32</sup> New Brunswick Minister of Health Dr. W.H. Roberts made a similar point two decades later in an address to the Canadian Public Health Association, when he

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<sup>30</sup> Gilliam, *A Text-Book of Practical Gynecology*, p. 3.

<sup>31</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), p. 26.

<sup>32</sup> J.N. Hutchnson, “National Physical Development,” *CJMS* 11, no. 1 (January 1902), p. 3.

argued that adolescence represented a “critical age” in a woman’s life, offering “the promise and our only assurance of the continuance of the human race,” there being “nothing in the whole range of life which can compare in importance with the potential powers of reproduction possessed by the girl of, say, fourteen years of age.”<sup>33</sup> Physicians placed the greatest emphasis on the damaging effects that education had on physical development during this crucial life stage.

Throughout the late nineteenth and early twentieth centuries, Canadian practitioners, often with emphatic figures like Smith at the forefront, expressed their opposition to women’s education on a regular basis.<sup>34</sup> Doctors put forward an increasingly medicalized and pathologized construction of the female body that built upon existing social and cultural images of late-Victorian fashionable femininity, and relied on arguments emphasizing the “nature” of the female body to lend authority to their messages.<sup>35</sup> Canadian physicians singled out the late nineteenth century desire to foster “precocious talent, refined taste, and vivacity” amongst Canadian youth as particularly problematic. The resulting “excessive development of the nervous system” and simultaneous “neglect of exercise and physical development” were framed as key factors contributing to a host of gynaecological complaints that were especially prevalent in so-called civilized women, “due to the customs of civilized life.”<sup>36</sup> In voicing their opposition to women’s education, turn-of-the-century medical experts built upon earlier

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<sup>33</sup> W.H. Roberts, “The Reconstruction of the Adolescent Period of Our Canadian Girl,” *PHJ* 10, no. 11 (November 1919), p. 491.

<sup>34</sup> Mitchinson has described Smith’s antagonism towards women’s education as “by far the most unrestrained attack found in the medical literature in the early decades of the century.” Mitchinson, *Body Failure*, p. 59

<sup>35</sup> Mitchinson, *The Nature of Their Bodies*, p. 356.

<sup>36</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 127-128.

arguments put forward, perhaps most popularly, in Edward H. Clarke's *Sex in Education, or A Fair Chance for Girls* (1873).<sup>37</sup> In 1905, Henry J. Garrigues, Professor of Gynaecology and Obstetrics at New York Maternity Hospital, singled out the education of young women as a key factor contributing to limited and incomplete physical development, arguing that it was "unwise" to overtax the brain during puberty "and the nearest following years, when the great change takes place in the uterus and the ovaries." Garrigues concluded, that, obviously, medical professionals could agree that "it is better for a woman to have healthy pelvic organs than to be able to read Horace and Sophocles in the originals."<sup>38</sup> Canadian practitioners agreed, arguing that "at the age of puberty, boys and girls should have a different course of education."<sup>39</sup> Smith was one of several physicians to recommend a revision in the curriculum during the final years of school. He suggested that

Algebra, Euclid [what we today might refer to as geometry], botany, chemistry, mythology, astronomy, Greek and Latin should be cut out, and the time devoted to dressmaking, millinery, cooking, and domestic economy, including the care of the baby, the making of the home, and even the care of the husband.<sup>40</sup>

Smith argued that under this new curriculum, by the time a girl left school at sixteen or seventeen, she would be "thoroughly prepared to become the best possible wife and

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<sup>37</sup> For more on Clarke see Warsh, *Prescribed Norms*, pp. 25-26.

<sup>38</sup> Henry J. Garrigues, *Gynaecology, Medical and Surgical – Outlines for Students and Practitioners* (Philadelphia: J.B. Lippincott and Company, 1905), p. 5. Canadian practitioners appear to have engaged with Clarke's argument over the following decades. Hutchinson, for example, cited Clarke in the reprint of his 1901 address. Hutchinson, "National Physical Development," *CJMS* (1902), pp. 3-4.

<sup>39</sup> A. Laphorn Smith, "Is the Present Method of Educating Girls Consistent with Their Physiological Development? And is it for the Welfare of the Race?" *Dominion Medical Monthly and Ontario Medical Journal (DMM)* 23, no. 5 (November 1904), pp. 322-323.

<sup>40</sup> Smith, "Is the Present Method of Educating Girls Consistent with Their Physiological Development?" *DMM* (1904), p. 323.

mother at eighteen.”<sup>41</sup> Other Canadian practitioners went so far as to argue for the need to incorporate an “intercalary period” for young women between the ages of fourteen and sixteen into the education system. They suggested that, during these years of a break from the traditional curriculum, a period of instruction “mainly clinical and observational, rather than didactic” would be devoted, vaguely, to appropriate education “with all matter peculiar to woman and womanhood.”<sup>42</sup> Finally, physicians held that these ill-effects of modern education were more felt by girls than boys, not only because of the innate weakness of the female body, but also because female students made “greater efforts to please their teachers” than their male counterparts.<sup>43</sup> While, as Mitchinson has argued, early concerns about the education of girls “never disappeared,” medical arguments on this issue considerably lessened in the decades following the First World War, as more and more Canadian universities opened their doors, at least partially, to young women.<sup>44</sup>

These tensions surrounding the education of girls and young women during puberty were often explicitly related to menstruation. During the period under study, menstruation was increasingly depicted in medical discourse as a pathological event, demanding, at the very least, rest and medical supervision or management. In a 1903 article in *Dominion Medical Monthly and Ontario Medical Journal (DMM)*, Dr. Jennie Drennan of St. Thomas, Ontario – a relatively rare female voice in these often male-dominated medical debates – observed that the cycle of ovulation, fecundation

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<sup>41</sup> Smith, “Is the Present Method of Educating Girls Consistent with Their Physiological Development?” *DMM* (1904), p. 323.

<sup>42</sup> Roberts, “The Reconstruction of the Adolescent Period of Our Canadian Girl,” *PHJ* (1919), p. 492.

<sup>43</sup> Atherton, “The Causes of the Degeneracy of the Human Race,” *CL* (1907), p. 98.

<sup>44</sup> Mitchinson, *Body Failure*, p. 60.

(fertilization and implantation), pregnancy, and lactation represented a “physiological generative cycle” that dominated the lives of most mammals. Drennan argued, that for the “modern” woman, however,

this cycle is interrupted by a lesser cycle, a monthly one, which consists of ovulation and menstruation; it is a pathological condition arising out of non-adherence to the laws of nature. In primitive woman, the larger cycle predominated, but as the scale of civilization is ascended, the lesser cycle becomes more and more prominent, until it predominates.<sup>45</sup>

The natural bodily state of woman, then, Drennan suggested, was to be at some point in the perpetual cycle of pregnancy, childbearing, and breastfeeding. Any deviation from this sequence, resulting in a reversion to the “lesser” menstrual cycle, was pathologized and depicted as a deviation from women’s natural role. At the same time, as will be discussed later in this chapter, pregnancy and childbirth were also increasingly pathologized. The result of these trends was that the bodies Canadian women, and especially those who could be classified as white, city-dwelling, and well to do, were consistently depicted as existing in a weakened or disease-like state.

Unsurprisingly, Laphorn Smith argued that participation in the traditional education system at a time when “the menstrual function makes great demands upon a girl’s strength” had adverse effects. Symptoms and medical conditions including “ovarian neuralgia” and high rates of “infantile uterus” in adult Canadian women arose due to the simple reality that “the average girl has not enough blood to meet the enormous demands

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<sup>45</sup> Jennie Drennan, “The Physiological Generative Cycle of Woman,” *Dominion Medical Monthly and Ontario Medical Journal (DMM)* 21, no. 3 (September 1903), p. 187. Highlighting the at times insular and provincial nature of medical periodicals throughout the period under discussion, Drennan’s article was also published under the same title in an issue of the *Canadian Journal of Medicine and Surgery* the following year. See *CJMS* 15, no. 2 (February 1904), pp. 89-93.

of the brain required by modern education, and the same time allow her organs of generation to grow as they should.”<sup>46</sup> Medical practitioners also argued that non-white girls and women had different experience of the menstrual function, but still emphasized the pathological nature of the process. Focusing on the relationship between climate, race, “primitive” conditions of living and menstruation, Charles Reed noted that cases of early menstruation were common amongst girls living in warm countries and tropical areas. He made it abundantly clear that that this was not a desirable condition, describing the racialized bodies of so-called “southern” girls and women as “so soon ripe and so soon rotten.”<sup>47</sup> Barton Cooke Hirst made a similar point in his 1912 text, arguing that the onset of menstruation amongst North American girls continued to be influenced by race, climate, and mode of life, in addition to heredity. He suggested that for those young women living in urban settings, “subjected, perhaps, to indiscriminate association with the other sex and to sexual temptations, the function appears earlier than it does in the country...the same rule applies to the lower animals.”<sup>48</sup>

Given the growing pathologization of puberty, menarche, and menstruation, it is not surprising that turn-of-the-century medical experts emphasized a growing need to

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<sup>46</sup> Smith clarified that his remarks applied “with greatest force to the girls in the High Schools.” Smith, “Is the Present Method of Educating Girls Consistent with Their Physiological Development?” *DMM* (1904), pp. 322, 327. Mitchinson has argued that over the course of the early twentieth century, menstruation became a “barometer” that physicians learned to “read” and interpret as evidence of women’s broader physical health or lack thereof. Mitchinson, *Body Failure*, p. 77.

<sup>47</sup> Reed, *A Text-Book of Gynaecology*, p. 703. Writing a decade later, Thomas Watts Eden weighed in on the issue, concluding that “climate [was] of less importance than race when it came to the onset of menstruation.” Eden, *A Manual of Gynaecology*, pp. 71-72.

<sup>48</sup> Hirst, *A Text-Book of Obstetrics*, p. 74. William P. Graves made similar comments about race and menstruation in his 1918 text. William P. Graves, *Gynecology* (Philadelphia and London: W.B. Saunders, 1918), p. 25. As will be discussed later in this chapter, comparisons between the bodies of women and those of animals pervaded much of mainstream medical discourse throughout this period.

effectively manage the bodies of girls and young women. These efforts, especially in the interwar period, as many lamented the recent loss of young Canadians, were part of a growing trend of medical professionals staking claim to the broader health of adolescents.<sup>49</sup> By the first decade of the century, leading periodicals, including the *Canada Lancet*, framed the parental and medical management of young female bodies as an imperative, arguing that “regularity and system [were] the essential requisites of success” in protecting the health of the “personally conducted” girl.<sup>50</sup> Building upon the process of professionalization that was well underway by this time, physicians also argued that medical supervision of these young bodies was far superior to any parental guidance that could be provided. In a 1913 article in the *PHJ*, for example, Adam Wright asserted the ongoing need for the family doctor to take an “active interest” in his young female patients, particularly during “the period when a girl is growing into womanhood...one of the most critical in her life.”<sup>51</sup> Wright chastised parents, and mothers, in particular, for their tendency to assume that their daughters would “grow out of” any health disturbances or abnormalities. He did concede, however, that mothers were the more receptive parent when it came to medical lessons on the value of preventing sickness.<sup>52</sup> Canadian practitioners increasingly agreed that it was their

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<sup>49</sup> See Cynthia Commachio, “‘The Rising Generation’: Laying Claim to the Health of Adolescents in English Canada,” *Canadian Bulletin of Medical History* 19, no. 1 (Spring 2002), pp. 139-178.

<sup>50</sup> “The ‘Personally Conducted’ School Girl,” *CL* 43, no. 5 (January 1910), p. 400.

<sup>51</sup> Adam H. Wright, “Preventative Medicine and The Family Doctor,” *PHJ* 4, no. 12 (December 1913), pp. 648-649.

<sup>52</sup> Wright, “Preventative Medicine and The Family Doctor,” *PHJ* (1913), p. 650.

responsibility to do everything possible to counter female delicacy and degeneration well before this decline manifested itself in a variety of corporeal complaints.<sup>53</sup>

Despite these preventative efforts, the health of adult Canadian women remained a cause for physician concern, with female bodies routinely depicted as existing in a disease-like state. Again, medical experts cited a variety of contributing causes, but, especially in the years before the emergence of the “modern girl” in the 1920s, singled out the dress and social habits of a particular group of women. In addition to chastising girls for their desire to pursue secondary or post-secondary education, Smith suggested in the closing decades of the nineteenth century that women’s pursuit of “a so-called nice figure” and the attendant habit of regularly wearing a corset had negative effects on overall health. Arguing that this attire prevented full respiration and damaged the health of the internal organs, Smith pointed out that the results of this habit were often pain and sensitivity in the reproductive organs. Commenting on the prevalence of gynaecological surgery to relieve such “women’s complaints,” Smith argued that “many time the removal of the corset would render unnecessary the removal of the ovaries.”<sup>54</sup> Physicians also expressed their anxieties at declining marriage rates, citing their belief that most

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<sup>53</sup> In 1908, J.E. Hanna claimed that it was the physicians “duty to begin the treatment of neurasthenia long before the patient breaks down, even years before it actually develops.” In his discussion of individual cases of neurasthenia, Hanna overwhelmingly focused on women’s experiences. J.E. Hanna, “Neurasthenia: Address Read Before the Medico-Chirurgical Society, Ottawa,” *Queen’s Medical Quarterly (QMQ)* 12, no. 4 (July 1908), p. 158.

<sup>54</sup> Smith argued that “The evils of the corset are very much increased by the error of suspending the greater part of the clothing from the waist instead of from the shoulders, as men do. The clothing of a fashionably dressed civilized woman, in winter street costume, has been estimated to weigh 37 pounds, 19 of which hang from the waist, so as to increase abdominal pressure.” Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), pp. 26-27. For more on the medical aspects of the dress reform movement see Eileen O’Connor, “Constructing Medical Social Authority on Dress in Victorian Canada,” *Canadian Bulletin of Medical History* 25, no. 2 (2008), pp. 391-406.



modern young women were no longer content with marriage. By choosing to enjoy the single life for too long, some suggested that well-to-do women were depleting their vitality and reproductive health with “all-afternoon card parties and all-night dancing parties, in darkened and ventilated rooms.”<sup>55</sup> Conditions afflicting adult women, including dysmenorrhea or painful menstruation, were consistently depicted in medical discourses as being brought on by deviation from the “natural” habits of living.<sup>56</sup> While all women were potentially at risk for these corporeal complaints – or, as Charles Penrose, Professor of Gynaecology at the University of Pennsylvania, described them, “the pathological conditions which, more or less, all females have in common” – physicians tended to agree that the “civilized woman” was more likely to be afflicted than “her barbarous sister,” due to her increasingly unnatural mode of life.<sup>57</sup>

These women were also seen as the most likely to suffer from “neurasthenia,” a term that along with hysteria, was increasingly used to describe a variety of complaints, and according to Cynthia Eagle Russett, a condition which was commonly held to be “the birthright of every civilized person.”<sup>58</sup> While women, in general, were described in

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<sup>55</sup> Smith, “Is the Present Method of Educating Girls Consistent With Their Physiological Development,” p. 327.

<sup>56</sup> This deviation was markedly associated with modernity. In contrast with those physicians who emphasized the risks that cycling posed to delicate female health, Dr. D. Gilbert Gordon, a physician at the Toronto General Hospital, recommended cycling as an appropriate exercise to be used in the treatment of neuralgic complaints including dysmenorrhea, writing that “the bicycle has done more to lessen the amount of fees paid to gynaecologists than all other drugs on the market put together.” See D. Gilbert Gordon, “Dysmenorrhoea,” *CL* 34, no. 5 (May 1901), p. 460.

<sup>57</sup> Charles Penrose, *A Text-Book of the Diseases of Women* (Philadelphia, New York, and London: W.W. Saunders and Company, 1904), p. 17. J. Bland-Sutton and Arthur E. Giles made this connection more explicit in their 1906 work, arguing that dysmenorrhea was more frequently found “in those of indolent habit of life.” J. Bland-Sutton and Arthur E. Giles, *The Diseases of Women: A Handbook for Students and Practitioners*, 5<sup>th</sup> Edition (London and New York: Rebman, 1906), p. 410.

<sup>58</sup> Russett, *Sexual Science*, p. 127.

mainstream medical discourses as having delicate nervous systems, upper-class women were perceived as having the most fragile nerves, and therefore, the weakest bodies of all. Kenneth Fenwick echoed this reasoning in his 1889 text to argue that neurasthenia, like dysmenorrhea, was a condition “most frequent in females of delicate organization” due to the tendency of these women to practice habits “connected with refinement and education, such as music, the reading of novels and poetry, the study of art, etc. which develop the emotional at the expense of the physical and intellectual.”<sup>59</sup> Canadian experts argued that rates of neurasthenia were alarmingly high. In a 1908 address to the Ottawa Medico-Chirurgical Society, physician J.E. Hanna estimated that 75% of Canadian women, “victims of would-be fashionable mothers or ignorant fathers,” exhibited neurasthenic symptoms, and as a result, were “a disgrace to the race.”<sup>60</sup> Concerns about the neurasthenic pressures of modern life persisted in the Canadian medical context until well into the twentieth century.<sup>61</sup>

Echoing other medical uses of mechanistic metaphors during the period, popular medical definitions of neurasthenia cast the body as a machine, running inefficiently on limited fuel and giving off limited heat.<sup>62</sup> While the nature of “hysteria” suggested an

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<sup>59</sup> Fenwick, *Manual of Obstetrics, Gynecology, and Pediatrics*, p. 189. Henry Turman Byford, Professor of Gynaecology at Northwestern University, made the same assessment in his 1895 text, arguing that neurasthenia was predominantly caused by “unhealthy modes of living.” Henry Turman Byford, *Manual of Gynaecology* (Philadelphia: P. Blakiston, Son & Co., 1895), p. 141.

<sup>60</sup> J.E. Hanna, “Neurasthenia: Address Read before the Medico-Chirurgical Society, Ottawa,” *QMQ* 12, no. 4 (July 1908), p. 159.

<sup>61</sup> A 1929 article published in the *Canadian Medical Association Journal*, for example, explored the relationship between noise and health. “Noise and Health,” *CMAJ* 20, no. 6 (June 1929), pp. 673-674. For more on the histories of neurasthenia and hysteria during this period, see David G. Schuster, *Neurasthenic Nation: America’s Search for Health, Happiness, and Comfort, 1869-1920* (New Brunswick: Rutgers University Press, 2011) and Andrew Scull, *Hysteria: The Disturbing History* (Oxford: Oxford University Press, 2009).

<sup>62</sup> J.E. Hanna described the condition as follows in 1908: “it is identical with what occurs in other mechanics or machines, like a hot water furnace; fuel and help are scarce, hence the heat is scant,

innate connection between the condition and reproduction, experts including George Miller Beard, the American neurologist most well-known for popularizing the term beginning in the early 1870s, depicted neurasthenia as a disorder also involving a close and reciprocal relationship with broader disturbances involving the reproductive system.<sup>63</sup> Neurasthenic symptoms were often perceived, by Canadian medical professionals and women alike, to manifest as “womb trouble,” with those women afflicted sometimes described as “womb cranks.”<sup>64</sup>

These perceptions had a marked impact on the treatment female patients received for a host of abdominal complaints. Leading medical practitioners, including Charles Reed, observed that hysterical patients readily accepted the suggestion – “often a spontaneous self-suggestion – of pelvic disease, especially as groin pain is so commonly a symptom of hysteria.”<sup>65</sup> Recalling his practice in late nineteenth century Fergus, Ontario, Abraham Groves described two cases in which female patients, quickly and superficially diagnosed with “ovarian disease” or “some uterine disease” received ovariectomies and were hospitalized “for many months without being cured,” before eventually being found to have appendicitis.<sup>66</sup> Practicing in Toronto decades later, Abraham Willinsky remembered several cases where senior physicians advocated hysterectomy and the removal of a healthy uterus as part of the treatment of general

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which primary condition is annoying and imprudent, but soon 100-fold greater mechanical complexities arise, the coils freeze and burst, the house, furniture and furnace are damaged, which cause infinitely more trouble and expense than the primary loss of heat, and these, reacting, intensify to the primary condition, for the furnace is damaged, and so the capability of producing heat is paralyzed.” Hanna, “Neurasthenia,” *QMQ* (1908), p. 159.

<sup>63</sup> George M. Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment* (New York: B.B. Treat, 1889), pp. 65, 74, 101, 110, 168.

<sup>64</sup> Hanna, “Neurasthenia,” *QMQ* (1908), p. 161.

<sup>65</sup> Reed, *A Text-Book of Gynecology*, p. 864.

<sup>66</sup> Groves, *All in the Day's Work*, pp. 37-38.

abdominal pain, despite the fact that thorough examinations showed no abnormalities.<sup>67</sup> Groves and Willinsky's experiences were grounded in a broader professional atmosphere which often saw physicians approach any bodily complaints experienced by their female patients, first and foremost, with the reproductive organs in mind.

This same atmosphere also saw Canadian women consistently depicted as the “needier” patients, requiring heightened medical surveillance and treatment at all stages of their lives. Howard Alexander, for example, recalled his experiences treating a husband and wife pair of patients in the late 1920s. He remembered that the wife was a regular visitor to his practice, with the husband stopping by to inquire year to year how much it cost him to keep his “good lady” “tinkered up” on a regular basis.<sup>68</sup> Perceptions of women's weakened bodies also influenced how physicians saw their patients as experiencing pain, shaping, in turn, how doctors perceived them as patients. Fenwick, for example, described his sensitive female patients as shrinking from pain and discomfort, abandoning exercise, and keeping “in the house or even in bed.” He concluded that these women routinely “craved sympathy.”<sup>69</sup> While this construction of a delicate and genteel femininity – with well-to-do women thought to emphasize or exaggerate their weakness and debility as “a mark of distinction” or a sign of “being above the common clay” – has been largely recognized by historians as a characteristic of the late-Victorian period, these views appear to have persisted over the coming decades.<sup>70</sup> As late as 1924, physicians continued to argue that a similar group of delicate middle to upper class

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<sup>67</sup> Willinsky, *A Doctor's Memoirs*, p. 80.

<sup>68</sup> Alexander, *56 Years in Medical Practice*, p. 22

<sup>69</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 190-191.

<sup>70</sup> Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New York: MacMillan Publishing Company, 1977), pp. 111-112.

women “generally have a marked craving for sympathy, and discuss their troubles both with their friends and the multitude of medical advisers they seek from time to time.”<sup>71</sup>

Fundamentally, while late nineteenth and early twentieth century medical experts agreed that the bodies of all women were, to a certain extent, in a state of decline, some women were perceived as more delicate than others. These increasingly delicate women, they argued, would be the ones to require the greatest medical attention and expert assistance during pregnancy and childbirth. In his 1876 work, *A Treatise on the Science and Practice of Midwifery*, Playfair reminded his fellow physicians that because of the compounding effects of civilization, “none of our patients are under physiologically healthy conditions.” As a result, Playfair continued, pregnancy and childbearing, “even under the most favorable conditions,” were events associated with “considerable risk” for many women.<sup>72</sup> Faced with a class of patients who, he suggested, were increasingly apt to share “a love of the comforts of illness and the persuasion of being delicate,” obstetricians and general practitioners were charged with bringing these women safely through these tumultuous periods of their reproductive lives.<sup>73</sup> At the same time, the recognition that “some women tolerate pain better than others,” coupled with physicians’ recurring arguments about the difficulty delineating “the boundary between what is normal and what constitutes a departure from the normal,” meant that the bodies of all women were increasingly depicted by experts as requiring medical observation, surveillance, treatment, and control.<sup>74</sup> Canadian medical experts increasingly framed

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<sup>71</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 677.

<sup>72</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 474.

<sup>73</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 481.

<sup>74</sup> Eden, *A Manual of Gynaecology*, p. 137.

these issues as matters of public concern, emphasizing the harsh reality that the majority of Canadian women could be expected to face “real hardship” in performing “the normal natural duties of wifehood and motherhood, and of raising an ordinary-sized family.”<sup>75</sup>

### Pathologizing Pregnancy

Throughout the late nineteenth and early twentieth centuries, the development and professionalization of the field of obstetrics went hand in hand with advances in other medical specialties, including gynaecology. As obstetrics and gynaecology evolved alongside one another, the two fields developed, in the eyes of many leading medical practitioners throughout the western world, a close and reciprocal relationship.<sup>76</sup> Well into the interwar period, the Canadian medical profession explicitly and implicitly emphasized the links between the two fields in a variety of ways. Canadian medical schools highlighted the similarities between obstetrics and gynaecology in the titles they offered professors, lecturers, demonstrators, and other teaching staff, as well as in the ways in which they organized and framed course offerings in the two subjects. Physicians also emphasized this relationship in many of the most popular medical texts they published throughout this period.<sup>77</sup>

In a 1929 article published in the *CMAJ* exploring “the matter with obstetrics,” Dr. Herbert Little suggested that the relationship between the two specialties shaped the

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<sup>75</sup> Smith, “Is the Present Method of Educating Girls Consistent with Their Physiological Development?” *DMM* p. 321. The eugenic, or, more accurately, dysgenic implications of female delicacy will be further discussed in Chapter 4.

<sup>76</sup> See Mitchinson, *Giving Birth in Canada*, p. 57.

<sup>77</sup> See, for example, Kerr, *A Combined Text-Book of Obstetrics and Gynaecology*, pp. 607, 609.

attitudes of many physicians when it came to pregnancy and childbirth. Discussing the development of obstetrics, Little surmised that

The rapid development of gynaecology dealing with the pathological conditions in the female genital tract, naturally resulted in scientific interest in the physiology [of the female reproductive organs]; the more so since the greater part of the surgical work of the gynaecologist was the repair of damage incident to labour... still closer union was inevitable. In most medical colleges the chairs of the two departments were united, and while this association has come to stay and has many advantages, there can be no doubt that in it lies the origins of many of our present difficulties...<sup>78</sup>

One of the results of the close and symbiotic relationship between obstetrics and gynaecology, given the latter's focus on the pathologies of the female reproductive system, was the increasing pathologization of both pregnancy and childbirth.

During the late nineteenth and early twentieth centuries, some physicians, including William Thompson Lusk, argued that as pregnancy represented (as Jennie Drennan also suggested) the natural state of the female body, there were exceptional women who experienced gestation as a period associated with "a particular sense of well-being."<sup>79</sup> Others like John Fairbairn, writing in the 1920s, suggested that "pregnancy, labour, and the puerperium were physiological, and not pathological states, and the woman at these times is not a sick woman."<sup>80</sup> Nevertheless, these practitioners continued to emphasize the pathological or disease-like symptoms associated with pregnancy that the majority of women experienced.<sup>81</sup> Lusk, for example, listed a host of "neuralgic

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<sup>78</sup> H.M. Little, "What's the Matter with Obstetrics?" *CMAJ* 20, no. 6 (June 1929), p. 646.

<sup>79</sup> Lusk, *The Science and Art of Midwifery*, p. 100.

<sup>80</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 23.

<sup>81</sup> See Fairbairn, *Gynaecology with Obstetrics*, p. 93.

affections” that most women could anticipate including face-ache, toothache, local anaesthesia, paresis, perversion of the senses, and attacks of dizziness and fainting. He also pointed out the radical changes in character associated with pregnancy, a period that made “the most amiable of women liable to become fretful, peevish, and unreasonable.”<sup>82</sup> The majority of Canadian physicians appear to have shared these attitudes, adopting pathological view of both pregnancy and parturition. Kingston physician and Queen’s Professor Kenneth Neander Fenwick took the emphasis on the many “nervous affections” that women were likely to experience during pregnancy a step further to draw parallels between the condition of the pregnant woman and that of “the young child,” simultaneously infantilizing female bodies and providing an effective argument for increasing the amount of prenatal care provided by medical experts.<sup>83</sup> Adam Wright also highlighted the physical discomforts associated with pregnancy throughout his career, arguing, for example, that “a certain amount of inconvenience and pain” was one of the earliest recognizable symptoms of conception.<sup>84</sup>

By the opening decades of the twentieth century, a growing number of physicians explicitly emphasized the pathological nature of pregnancy. Edward P. Davis, Professor of Obstetrics at Jefferson Medical College in Philadelphia, argued in a 1917 article published in *Dominion Medical Monthly* that in order to prevent heightened pain in giving birth, the doctor should endeavor “to bring about as nearly a physiological

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<sup>82</sup> Lusk, *The Science and Art of Midwifery*, p. 100. Other practitioners echoed these assertions. J. Clifton Edgar argued in 1907 that hysterical symptoms were “more or less common in all pregnant women” as the existence of pregnancy render[ed] the mental imbalance of woman unstable, and an hysterical attack may be precipitated on the slightest occasion.” Edgar, *The Practice of Obstetrics*, p. 335.

<sup>83</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 91.

<sup>84</sup> Wright, *A Text-Book of Obstetrics*, p. 211.



condition of the patient as possible” during pregnancy. This statement suggests, in a sense, that the assumption that gestation was a pathological bodily state was a view increasingly held by the majority of mainstream medical practitioners.<sup>85</sup> This pathological emphasis, with experts enumerating the symptoms that could lead to a diagnosis of pregnancy, continued into the post-WWII period.<sup>86</sup>

Adopting a largely pathological view of the entire process, medical experts frequently commented on the ongoing difficulties in evaluating and conceptualizing women’s bodily experiences during the gestation period. As Fenwick suggested in his 1889 text, many physicians found it “impossible to draw a line between the rational signs and symptoms of pregnancy, between the normal and the abnormal.” Fenwick continued: “The simple nervousness of pregnancy may be so augmented as to result in convulsions; the nausea may result in distressing and dangerous vomiting; the fullness of the blood-vessels may lead to general plethora or local congestion; the normal merges into the abnormal; the healthy into disease.”<sup>87</sup> The minority of medical practitioners continuing to argue that pregnancy represented a physiological or “normal” bodily process also, interestingly, made the same point. Suggesting that Canadian physicians ought to “look upon pregnancy and labour as perfectly physiological, even in our advanced state of civilization,” Drs. F.E. Rice and E.E. Bissett conceded in a 1928 article published in the *Public Health Journal* that “the balance between health and disease is much finer than in the non-pregnant state,” particularly as latent disease and bodily weakness had the

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<sup>85</sup> Edward P. Davis, “Painless Childbirth,” *DMM* 48, no. 4 (April 1917), p. 80.

<sup>86</sup> See, for example, Scott and Van Wyck, *The Essentials of Obstetrics and Gynaecology* (1947), p. 62.

<sup>87</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 29.

potential to resurface during pregnancy.<sup>88</sup> Even J. Whitridge Williams, arguably the obstetrician behind some of the most vocal calls for a continued “hands off” approach to the natural and physiological event which was birth,<sup>89</sup> noted that “the borderline between health and disease is less distinctly marked during gestation than at other times.” As a result, Williams argued, any deviations from the physician-defined “normal” standard of health for women were recognized as the potential “precursors of pathological conditions which may seriously threaten the life of the mother or the child.”<sup>90</sup> Given that women were regularly assumed to be less healthy than men, and the fact that anxieties about the delicate health of middle and upper-class white women persisted throughout this period, there were many potential causes for concern. As a period associated with the blurring of lines between normal and abnormal, and between health and disease, physicians from both viewpoints agreed that pregnancy required increasing medical attention and treatment. This was the case, practitioners argued, for some women more so than others.

During the late nineteenth and early twentieth centuries, medical practitioners routinely cited the upbringing, lifestyle habits, class, and race of their patients as key factors shaping both female bodies and the ways in which individual women experienced a host of “female complaints.” These factors were also seen as having a significant impact on individual experiences of pregnancy throughout this period. Arising out of growing concerns surrounding “miasma” over the course of the nineteenth century, medical experts argued that those women who had the greatest access to fresh air had

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<sup>88</sup> F.E. Rice and E.E. Bissett, “Report on Maternal Mortality,” *PHJ* 19, no. 12 (December 1928), p. 578.

<sup>89</sup> Wolf, *Deliver Me From Pain*, p. 2.

<sup>90</sup> Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 247.

healthier and less pathological pregnancies than their city-dwelling counterparts.<sup>91</sup> Those women seen to be living the most “modern” or “unnatural” lives, physicians pointed out, were more likely to experience difficulties. As the “New Women” of the 1890s and early 1900s, and the “modern girls” of the decades that followed became increasingly mobile and partook in many of the technological changes and possibilities of the early twentieth century, physicians singled out new behaviours as a cause for concern.<sup>92</sup> A 1915 editorial published in the *CJMS* described lengthy automobile rides and “prolonged sitting” as “weakening the muscles through disuse that will later be required in the expulsion of the fetus,” and thereby, contributing to exceedingly difficult and painful labours. Careful and appropriate exercise during pregnancy was recommended to counter the damaging effects of modern life.<sup>93</sup> Those women who were forced to carry out their own household chores, on the other hand, were described by *CJMS* editors as “the class *par excellence*,” and provided they restrained themselves from excessive reaching or climbing, were ruled to have the most healthful pregnancies.<sup>94</sup>

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<sup>91</sup> Lusk, for example, argued that “as a rule, a rural neighbourhood is more conducive to normal pregnancy than large cities,” arguing that women “reared amid the refinements of civilization” were likely to experience heightened discomfort throughout the entire gestation period. Lusk, *The Science and Art of Midwifery*, pp. 120-121.

<sup>92</sup> Jane Nicholas has argued that the 1920s were a period of potent anxiety surrounding the effects of such technological changes on “the modern girl” – a cultural construction that “sometimes overlapped” with the “New Woman” of previous decades. Automobiles, in particular, were singled out for the potential freedom and danger they offered: “zooming down roads could be a metaphor for the quick pace of city life and cultural change.” Nicholas, *The Modern Girl*, pp. 5, 210.

<sup>93</sup> The editors recommended, somewhat surprisingly, golf as the ideal activity for the pregnant woman citing the following reasons: “It is private. There is no team work. The costume is loose and light. The hours are entirely within one’s choice. One’s companions are congenial.” “Editorial: Pre-Natal Care,” *CJMS* 38, no. 4 (October 1915), p. 111. This comment suggests that physicians were not referring to the working classes.

<sup>94</sup> Editors concluded that “work itself is a sedative” for the pregnant woman. “Editorial: Pre-Natal Care,” *CJMS* (1915), p. 111.

Other physicians, writing during the interwar period, adopted a similar perspective, singling out the two types of women occupying the extreme highs and lows of the social hierarchy – “the wealthy and luxurious class” and “the underfed and overworked” – as having the most difficult pregnancies.<sup>95</sup> These views were by no means limited to physicians. Early twentieth century nurses, for example, were also routinely taught that “the higher the patient stands in the social scale, the more likely is her nervous system to break down under the strain of pregnancy.” Nurses were advised that they were more likely to encounter such “complicated” patients in their private practice, as opposed to during hospital training, where, well into the twentieth century, it was assumed that the majority of obstetric patients would hail from the working classes.<sup>96</sup> This same group of women, physicians suggested, represented the bulk of obstetric patients the average Canadian practitioner encountered during his private practice, a fact that had a marked impact on the ways in which both pregnancy and birth were represented in medical discourse throughout this period.

### Parturition and Pain: The Ongoing Pathologization of Childbirth

Just as Canadian medical experts engaged in professional debates over the nature of pregnancy throughout the late nineteenth and early twentieth centuries, so too did they discuss the nature of parturition or birth during these transformative decades. Ultimately, they concluded that, like pregnancy, childbirth was a pathological process requiring medical supervision, management, and control. This was the case, physicians suggested,

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<sup>95</sup> Kerr, *Combined Text-Book of Obstetrics and Gynaecology for Students and Medical Practitioners*, p. 153.

<sup>96</sup> Cooke, *A Nurse's Handbook of Obstetrics*, p. 70.

for some women more than others, with the class, age, and race of the woman in question having a marked effect on how medical experts perceived individual birth experiences.

The pathologization of childbirth in Canadian medical discourses was well underway by the closing decades of the nineteenth century. Practitioners, including Kenneth Neander Fenwick, routinely adopted pathological language in their most basic descriptions of parturition, reciting the many “symptoms” associated with the onset of labour and referring to the foetus, throughout the process, as the “abdominal tumour.”<sup>97</sup> In 1913, Joseph B. DeLee, perhaps the most ardent supporter of a pathological view of birth during this period, posed the question:

Can a function so perilous, that in spite of the best care, it kills thousands of women every year, that leaves a quarter of women more or less invalided, and a majority with a permanent anatomic change of structure, that is always attended by severe pain and tearing of tissues, and that kills 3 to 5 per cent of children – can such a function be called normal?

DeLee concluded that his experience to date had convinced him that “not the majority, but the minority of labor cases is [sic] normal, and that not until the pathologic dignity of obstetrics is fully recognized may we hope for any considerable reduction of the mortality and morbidity of childbirth.”<sup>98</sup> Canadian practitioners appear to have, over the coming decades, increasingly agreed with these views. A review of the 1928 edition of DeLee’s text (an edition that included the same passage, which was singled out for

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<sup>97</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 42-44. In some ways this pathological language escalated in the early twentieth century. Joseph B. DeLee, for example, relied on this same description of the “abdominal tumour” but went on to argue that, fundamentally, every confinement had to be understood by the physician as “a major surgical case.” DeLee, *The Principles and Practice of Obstetrics*, pp. 227, 231.

<sup>98</sup> DeLee, *The Principles and Practice of Obstetrics*, xii, xiii.

comment) in the *Canada Lancet and Practitioner (CLP)* concluded that DeLee was “not alone in this gloomy presentation” of the nature of birth: “Many obstetrical authorities agree with him. Pregnancy and labor are no longer normal processes.”<sup>99</sup> In this statement, the editors of the *CLP* encapsulated an opinion that had been increasingly expressed by other practitioners – the idea that the nature of birth was somehow changing in the twentieth century, due in large part to the negative effects of modern life.

Obstetricians and general practitioners alike debated the difficulty in distinguishing the normal from the abnormal when it came to pregnancy, and, naturally, they carried these same discussions forward when considering the condition of their parturient patients and their experiences in the birthing room. The authors of many of the most popular medical texts published in the first half of the twentieth century readily admitted that “the border-line between a normal and abnormal labour is not clear cut,”<sup>100</sup> and framed childbirth as “a condition which, though it is called physiological, borders so closely on the pathological, very little is required to pass the boundary-line into disease.”<sup>101</sup> While some practitioners concluded that labour was, as nature intended it, a physiological and natural process, they were quick to point out that this was, in their expert assessment, no longer the case. Again, these arguments, increasingly made in the interwar period, were all the more significant as the reproductive capacity of Canadian women took on new significance in view of the massive losses associated with the First World War. In an address delivered before the Sudbury Medical Society in June 1925,

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<sup>99</sup> “Editorial: Labor – Physiological or Pathological?” *Canada Lancet and Practitioner* 71, no. 4 (October 1928), p. 122.

<sup>100</sup> Kerr, *Combined Text-Book of Obstetrics and Gynaecology*, p. 332.

<sup>101</sup> Hirst, *A Text-Book of Obstetrics*, p. 206.

Dr. W.B. Tew, representing the Department of Obstetrics and Gynaecology at the University of Western Ontario, surmised that childbirth was “a perfectly natural event when the conditions accompanying it are natural. In normal cases, the attendance of midwives or obstetricians might be regarded in the light of luxuries. There are times, however, when the event no longer remains within physiological limitations.”<sup>102</sup> Though Tew singled out the “normal case” as a natural event requiring little in the way of medical intervention, students at the University of Western Ontario had long been taught that “few [obstetric] cases are normal in this present civilized century.”<sup>103</sup> Physicians, then, expressed a clear disdain for modernity and its effects on the female body. In a 1928 address read before the Section of Obstetrics and Gynaecology at the Toronto Academy of Medicine, Kennedy C. McIlwraith, Associate Professor of Obstetrics at the University of Toronto and Senior Obstetric Surgeon at the Burnside Lying-In Hospital, suggested that childbirth represented “a physiological process undoubtedly, but no longer functioning physiologically, because of changed circumstance.” The result, McIlwraith argued, was the pain, morbidity, and death women experienced in reproducing.<sup>104</sup> The pathologization of birth continued well into the mid-twentieth century.<sup>105</sup>

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<sup>102</sup> W.P. Tew, “The Use and Abuse of the Obstetrical Forceps,” *CMAJ* 15, no. 10 (October 1925), p. 1031.

<sup>103</sup> J.M. Smith, Lecture Notes on Obstetrics (as taken from Dr. Meek or Dr. Eccles), University of Western Ontario, 1900, A00-194-01, Archives Research and Collections Centre, Western University.

<sup>104</sup> Kennedy C. McIlwraith, “The Obstetrician’s ‘Raison d’Etre’,” *CMAJ* 18, no. 3 (March 1928), p. 324.

<sup>105</sup> In a 1941 article in the *CMAJ*, Dr. N.W. Philpott argued that “childbearing has become increasingly more difficult and what was once known as a physiological process, seems now to be less physiological and more aptly termed ‘a painful ordeal’.” N.W. Philpott, “Local Anaesthesia in Obstetrics,” *CMAJ* 45, no. 6 (December 1941), p. 539.

There were Canadian detractors of this increasingly pathological view of obstetrics. W.W. Chipman, Professor of Obstetrics and Gynaecology at McGill University argued that parturition represented “a physiological process, identical in the countess and the cow,” and repeatedly suggested that labour was completely physiological, “if the woman is but let alone.”<sup>106</sup> While most Canadian practitioners during this period decried unnecessary obstetrical influence and “meddlesome midwifery,” especially in textbooks, Chipman was a particularly vocal opponent of intervention, describing several patients he had encountered as “mutilated beyond hope of complete repair” as a result of the ill-advised use of forceps.<sup>107</sup> Views on the physiological versus pathological nature of childbirth – and, as a result, the amount of medical interference required – were fundamentally shaped by the training students received. William Victor Johnston, for example, described how his time as a medical student in the 1920s shaped him, like Chipman and Whitridge Williams, into a “cautious, even timid obstetrician, both by training and choice,” and recalled the advice of one mentor, Dr. Harold Taylor of Goderich, Ontario, who taught him to avoid the use of forceps unless he was “prepared to walk two miles to get them.”<sup>108</sup> John Hunter, on the other hand, recalled that the routine successful use of forceps during his time as a medical student at U of T in the late nineteenth century “made an addict” of one of his fellow students, “who subsequently used them in about seventy-five per cent of the cases in a

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<sup>106</sup> W.W. Chipman, “Problems of Obstetrical Practice,” *CMAJ* 13, no. 6 (June 1923), p. 379; W.W. Chipman, “Some Conclusions after a Symposium on Obstetrics,” *CMAJ* 14, no. 8 (August 1924), p. 704.

<sup>107</sup> W.W. Chipman, “Symposium on Obstetrics – Some End Results,” *CMAJ* 16, no. 6 (June 1926), p. 682. Given growing pronatalism in the years following the First World War, the ill effects of such interventions could be seen as doubly damaging, having a negative impact on both the women in question, and the health of the Anglo-Canadian race.

<sup>108</sup> Johnston, *Before the Age of Miracles*, pp. 40, 51.



very large obstetric practice (1875-1925) and without any cause of regret for having done so.”<sup>109</sup>

Chipman’s perspective, however, represented the views of a minority of Canadian physicians. The majority conceded that, even if not wholly pathological in nature, modern childbirth demanded increased medical surveillance, guidance, and often, intervention. Writing in 1889, Fenwick reminded the next generation of Canadian practitioners that “were labour always the natural physiological process it ought to be, no treatment whatever would be demanded.”<sup>110</sup> By placing an increasing emphasis on the management and treatment of all births over the course of the late nineteenth and early twentieth centuries, Canadian doctors implicitly, and often explicitly, suggested that this was not the case. The fact that things were not always as they ought to be also justified Canadian medical schools’ focus on the pathological nature of obstetrics. As Adam Wright asserted in his 1908 text, no practitioner could “intelligently understand all about normal labor until he has a good knowledge of anatomy, physiology, and pathology, and in addition, has gained a knowledge which will enable him to detect the first sign or symptom of abnormality in any form.”<sup>111</sup>

The growing pathologization of pregnancy and childbirth was fundamentally reinforced by mounting anxieties surrounding infant and maternal mortality during the first half of the twentieth century, particularly in the years following the First World War. As historians have argued, “the Great War caused a quantum leap in the concern about

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<sup>109</sup> John Hunter, “Half a Century in Medicine, 1875-1925,” *CJMS* 64, no. 3 (September 1928), p. 73.

<sup>110</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 59.

<sup>111</sup> Wright, *A Text-Book of Obstetrics*, p. 85.

conserving human life.”<sup>112</sup> These concerns naturally centred on protecting the health and lives of Canadian mothers and children. While infant mortality had begun to decline by the 1920s, medical experts recognized that death rates for women in childbirth remained more or less constant throughout the first third of century, at a rate of about 5.5 deaths per 1000 mothers. When these numbers “began to edge upward even more” with the onset of the Depression, widespread attention to the issue of maternal mortality prompted a national enquiry, along with a host of other studies into the issue.<sup>113</sup> Canadian experts, with the U of T’s Dr. Helen MacMurchy at the fore, argued that medicalized birth was necessary to save Canada’s mothers.<sup>114</sup> Throughout the interwar period, Canadian doctors also considered other factors, at times, looking inward at their own profession. A 1934 study of maternal deaths in Ontario between 1927 and 1931 found that 17.7 per cent of all deaths in the province among women aged 20 to 39 were “the direct result of pregnancy and child-bearing.”<sup>115</sup> Physicians singled out the practitioner who neglected to recognize the very real risks and pathologies of the process of giving birth as responsible for many of these fatalities. Kennedy McIlwraith, for example, placed the blame for high rates of maternal mortality squarely on “the man who calls childbirth a ‘physiological process’ and lets it go at that.”<sup>116</sup> Recognizing the pathological nature of birth, then, became a practical and conservative strategy for many Canadian physicians. By adopting

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<sup>112</sup> Valverde, *The Age of Light, Soap, and Water*, p. 24.

<sup>113</sup> Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: University of Toronto Press, 1990), p. 33.

<sup>114</sup> See Helen MacMurchy, *Need Our Mothers Die? A Study Made by a Special Committee on the Division of Maternal and Child Hygiene* (Ottawa: Canadian Welfare Council, 1935).

<sup>115</sup> J.T. Phair and A.H. Sellers, “A Study of Maternal Deaths in the Province of Ontario,” *CPHJ* 25, no. 12 (December 1934), p. 563.

<sup>116</sup> Kennedy C. McIlwraith, “How to Reduce Maternal Mortality in the Province,” *CPHJ* 22, no. 7 (July 1931), p. 350.

this perspective and keeping a constant eye out for any abnormalities, practitioners saw themselves as having a greater chance of safeguarding both the health of their female patients, and their professional reputations.

### Factors Shaping Feminine Sensitivity: Class, Age, and Race

A key part of the ongoing, and arguably increasing, pathologization of pregnancy and parturition was an emphasis on the heightened levels of pain that modern women were thought to face in the birthing room. Medical practitioners routinely noted that the idea that women experienced pain and sorrow in giving birth was nothing new. DeLee commented in his 1913 text that “writers of all ages have described labor as painful,”<sup>117</sup> and Canadian physicians made similar assessments. In a 1923 article published in the *CMAJ*, Dr. Ross Mitchell, Associate Professor of Obstetrics at the University of Manitoba, for example, commented that “throughout the ages childbirth and pain have been associated in men’s minds,” and concluded, arguing for greater expertise in the administration of pain relief during labour, that “the primal curse pronounced upon woman has never been revoked.”<sup>118</sup> At the August 1930 joint meeting of the British and Canadian Medical Associations, Dame Louise McIlroy, Professor of Obstetrics and Gynaecology at the University of London commented to practitioners from both sides of the pond that “the agony of childbearing is almost worse than any other suffering.”<sup>119</sup> Arguments about the exceptional nature of labour pain were nothing new. Lusk, for

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<sup>117</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 117.

<sup>118</sup> Ross Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* 13, no. 10 (October 1923), p. 718.

<sup>119</sup> Louise A. McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* 24, no. 1 (January 1931), p. 21.

example, had argued in his 1888 text that “women in childbirth are at times subjected to pain exceeding that of the rack and the thumbscrew.”<sup>120</sup> The late nineteenth and early twentieth centuries, however, did see a growing emphasis on the varying levels of pain that women were expected to experience in giving birth. Though Canadian physicians readily expressed the belief that “labor in woman was foreordained as a curse,” they argued, as Dr. J. McArthur of London, Ontario suggested at a January 1907 meeting of the London Medical Society, that the suffering and difficulties associated with childbirth were “still made more difficult by the intellectual evolution of the human race, which has increased the brain, and consequently its coverings, without a corresponding increase in the pelvis.”<sup>121</sup> While all “modern” women faced heightened pain, physicians expressed the belief that different types of women, based on prevailing medical theories and social attitudes about various female bodies, would experience varying levels of agony in giving birth.

McArthur’s argument about the difficulties “modern” and “evolved” women faced in giving birth was by no means new. After the publication of Darwin’s *On the Origin of Species* in 1859, medical practitioners throughout the western world increasingly relied on the language of evolution, or, more accurately, devolution, to describe how the bodies and births of modern women compared to those of their more natural counterparts of previous generations. Idealizing the antimodern bodies of women in the past, William Heath Byford argued in his 1870 text that “women of muscular make, who are strong and self-reliant, more generally have easy labors, especially if they

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<sup>120</sup> Lusk, *The Science and Art of Obstetrics*, p. 640.

<sup>121</sup> J. McArthur, “Care of the Perineum in Connection with Labor,” *DMM* 28, no. 3 (March 1907), p. 116.

are of active habits. As general good health and strength increase the favorable chances in labor, so do bad health and great debility add to its dangers and duration.”<sup>122</sup> Byford concluded, however, that there were many exceptions to this rule. While he wholeheartedly believed that “in the vast majority of cases, parturition is accompanied by intense suffering,” William Smoult Playfair specified in his 1876 text that “the amount of suffering experienced during labor varies much in different cases, and is no doubt, in direct proportion to the nervous susceptibility of the patient.”<sup>123</sup> In the coming decades, other physicians took up this line of reasoning to argue that evolution, and the accompanying development of the nervous system, had deleterious effects on the modern woman’s experience of labour. Lusk singled out “hysterical women” and “excitable persons” as most likely to experience “agonizing” pains even in the first stage of labour, while Edgar explicitly pointed out that the intensity of pain during childbirth “varied greatly depending on the bodily constitution and nervous organization of the patient.”<sup>124</sup> Also recognizing “much individual difference in women regarding the pain of labor,” DeLee argued that the experiences and behaviour of the growing group of women with highly-developed nervous systems gave “otherwise normal labor a pathologic trend,” shaping the perspectives of many physicians.<sup>125</sup> In much of the professional medical literature published throughout this period, physicians implied that this group of women hailed largely from the middle and upper classes.

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<sup>122</sup> Byford, *A Treatise on the Theory and Practice of Obstetrics*, p. 216.

<sup>123</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 233.

<sup>124</sup> Lusk, *The Science and Art of Midwifery*, pp. 452, 460; Edgar, *The Practice of Obstetrics*, p. 430.

<sup>125</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 118.

By the late-Victorian years, experts in the emerging field of obstetrics placed increasing emphasis on the highly painful labours of well-to-do women, who were often seen as occupying a higher rung on the evolutionary hierarchy than their working class counterparts. Mainstream medical rhetoric held that as such women possessed highly-evolved nervous systems, and accordingly, a heightened sensitivity to pain of all types, including during childbirth. Again, the Canadian doctor Laphorn Smith was a vocal proponent of these theories. Throughout his career, Smith argued the bodies of wealthy women – those in the habit of living luxurious lives and having “things done for them instead of doing themselves” – were weak and inefficient, incapable of uterine dilation. Though relatively few Canadian women would have been in the position to avoid all domestic tasks, doctors like Smith argued that well-to-do women, more generally, were “more sensible to pain and less capable of exertion.” For all civilized women, physicians suggested, labour had become “a long and agonizing process, owing to their increased sensibility with diminished contractility. Their muscles make a great outcry but do very little work.”<sup>126</sup> Smith also argued that when compared with obstetric patients from “the uneducated classes in Canada,” such women were also more likely to experience “early spontaneous rupture of the amniotic sac,” resulting in a dry, tedious, and exhausting labour that would often lead to forceps delivery and “a badly ruptured perineum.”<sup>127</sup> This group of delicate women, physicians argued, also required more modern medical

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<sup>126</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), pp. 27-28.

<sup>127</sup> Smith, “Is the Present Method of Educating Girls Consistent with their Physiological Development?” *DMM* (1904), p. 325. In this article, published 15 years after his piece in the *CMR*, Smith made the same arguments about civilization, class, pain, and childbirth, almost word for word. While this highlights the repetitive nature of medical discourse at the turn of the twentieth century, it also shows how deeply these ideas were held for some individual practitioners.

assistance during childbirth. In a 1907 article published in *Dominion Medical Monthly*, London physician J. McArthur suggested that “the higher the social circle, or...the greater the culture and refinement,” the more unlikely the patient was to experience a problem-free labour, delivering without damage to the perineum.<sup>128</sup> In these cases, then, the obstetrician would likely be required to repair perineal tears after delivery. Additionally, and contrary to the older and long-stated opposition to “meddlesome midwifery,” physicians also argued that when confining “civilized” patients, it was “often impossible to leave the third stage of labor [the delivery of the placenta] entirely to nature,” due to the heightened risks for septicemia associated with a retained placenta.<sup>129</sup> The effects of improper and indolent habits among the upper classes were also seen to extend beyond the birthing room, with this group of women singled out as having some of the greatest difficulties in breastfeeding their infants, to the detriment of both the children in question and the Anglo-Canadian race.<sup>130</sup>

While physicians agreed that higher education and indolent habits made motherhood “exceedingly difficult,” medical practitioners also suggested that the pressures and temptations of modern life made marriage “distasteful” for many young Canadian women.<sup>131</sup> As a result, experts argued, by the first decades of the twentieth century women throughout the Western world, in “countries in which the highest degree of civilization has been reached,” were marrying and having children at more advanced

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<sup>128</sup> J. McArthur, “Care of the Perineum in Connection with Labor,” *DMM* 28, no. 3 (March 1907), p. 116.

<sup>129</sup> Hirst, *A Text-Book of Obstetrics*, p. 182.

<sup>130</sup> Howard Spohn, “The Healthy Child – Our Greatest National Asset,” *PHJ* 12, no. 8 (August 1921), p. 356.

<sup>131</sup> Smith, “Is the Present Method of Educating Girls Consistent with Their Physiological Development?” *DMM* (1904), p. 24.

ages than ever before.<sup>132</sup> Obstetricians argued that labour would be exceedingly painful and difficult for these “elderly” first time mothers, who were likely to require greater operative interference in the birthing room, and bear children with lower birth weights and higher risks of mortality.<sup>133</sup> At the same time, those involved with a growing eugenics movement throughout English Canada, fuelled by high rates of immigration in the years before the First World War, took note of the high fertility rates of “inferior immigrant families” as compared to “superior native Canadians.”<sup>134</sup> In this context, practitioners were all the more concerned about the birthing difficulties experienced by “elderly” Anglo-Canadian primiparae. Well into the twentieth century, Canadian physicians routinely emphasized that young mothers had an easier time in delivering,<sup>135</sup> and found the early twenties to be the safest period for childbearing.<sup>136</sup>

In much of the medical discourse of the period, the childbirth experiences of well-to-do – and, at times, “elderly” – first time mothers were routinely contrasted with descriptions of the confinements of their working-class and rural counterparts. Some

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<sup>132</sup> Charles Harrington, *A Manual of Practical Hygiene for Students, Physicians, and Health Officers* (Philadelphia: Lea and Febiger, 1914), p. 886.

<sup>133</sup> Practitioners disagreed, however, about the age at which a first-time mother could be classified as “elderly,” though most in the early twentieth century agreed that this happened between the ages of 28 and 32. See Edgar, *The Practice of Obstetrics*, p. 66; Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 284.

<sup>134</sup> McLaren, *Our Own Master Race*, p. 55. Both McLaren and Erika Dyck have identified the wide-reaching nature of the eugenics movement in early twentieth century Canada, with Dyck arguing that “immigration posed eugenic questions in the early part of the century in a manner that fused elements of class, race, and intelligence” as “foreigner” became a “convenient shorthand” for “undesirable.” Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), p. 7.

<sup>135</sup> McIlwraith argued that “very young mothers” had the easiest confinements, as “ossification of the pelvic joints has not yet begun, and the other tissues are softer.” He expressed alarm at the fact that amongst the current generation “the average primipara is more than twenty-one.” McIlwraith, “The Obstetrician’s ‘Raison d’Etre’,” *CMAJ* (1928), p. 325.

<sup>136</sup> F.W. Jackson, N.R. Rawson, and E. Couture, “Maternal Mortality in Manitoba,” *CPHJ* 31, no. 7 (July 1940), p. 311.



medical practitioners made explicit comparisons between classes. DeLee, for example, argued that in his “civilized country” – the United States of America – “poor, hard-working women” generally had easier and shorter labours when compared with “the rich and pampered.”<sup>137</sup> Other physicians relied on case examples from their lower-class patients who experienced “nearly painless labors.” Edgar, for example, recalled in his 1907 text a suspected case of infanticide in which a primipara mother, the servant of a wealthy family, gave birth out of wedlock, allegedly mistaking “a nearly painless labor for a difficult defecation” with the child “born in the pan of the water-closet.” He also recounted the case of a multiparous mother, a resident of “a New York tenement,” who gave birth while hauling in a loaded clothes-line, asserting that the mother “was unaware of labor until the child, near term, struck the iron floor of the fire escape.”<sup>138</sup> Medical perceptions of class-based differences in sensitivity extended beyond obstetric cases.<sup>139</sup> At the same time, physicians warned of the toll excessive work could take on the “physically exhausted and ill nourished” bodies of destitute pregnant women, casting the “excessive burdens” of both paid employment and heavy housework as problematic and “undesirable, especially during pregnancy.”<sup>140</sup>

For those women living in rural settings, the combination of physical work and fresh air was seen to have a particularly positive impact on birth experiences. Canadian

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<sup>137</sup> DeLee also argued that the labours of city-dwelling women were longer than those of their country-dwelling counterparts. DeLee, *The Principles and Practice of Obstetrics*, pp. 118, 132.

<sup>138</sup> Edgar, *The Practice of Obstetrics*, p. 450.

<sup>139</sup> Willinsky, for example, commented that his working-class Toronto patients preferred to schedule surgeries on Saturday afternoons to avoid missing work on Mondays, but pointed out that this was often not a problem as ‘the recovery was usually rapid: most of them were such hard working people with a high threshold of pain.’ Willinsky, *A Doctor’s Memoirs*, p. 90.

<sup>140</sup> See Fairbarin, *Gynecology with Obstetrics*, p. 735; “Women in Industry,” *Canadian Doctor* 9, no. 5 (May 1943), p. 25.

physicians including Thomas R. Ponton of MacGregor, Manitoba, argued that the many hardships rural women encountered in their day to day lives, made for “a better class of patients” and “undoubtedly less trouble in labor.” Citing case examples and arguing that this class of patients rarely experienced hemorrhage during or after delivery, Ponton concluded that country doctors could attribute the relatively easy deliveries of rural women to

the greater muscular development of our patient. They, as a rule, have little or no assistance in their work during pregnancy. The reason for this is either lack of available help or lack of money with which to pay. As a result, our patients, when they come to confinement, are muscular and healthy.<sup>141</sup>

In this argument, then, class and mode of life were seen as converging to create healthful conditions for both pregnancy and birth. The perceived relationship between rural lifestyles and easier births went hand in hand with growing public health panics surrounding the higher rates of maternal and infant mortality in urban settings as compared to rural environments. Helen MacMurchy reported that in 1922, the Canada-wide mortality rate for urban births, at 6.7 deaths per 1000 live births, outstripped the rural mortality rate (4.4/1000). A decade later, an article published in the *CPHJ* made note of mounting anxieties surrounding “the steady increase in [maternal] deaths in cities and towns with populations over 5000.” Within the province of Ontario, maternal mortality in urban areas was calculated at 7.38%, compared to 3.33% in rural areas.<sup>142</sup>

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<sup>141</sup> Thomas R. Ponton, “Obstetrical Experiences in Country Practice,” *WCMJ* 3, no. 7 (July 1909), pp. 312-315.

<sup>142</sup> Helen MacMurchy, “On Maternal Mortality in Canada,” *PHJ* 16, no. 9 (September 1925), p. 412; J.T. Phair, “Maternal Mortality – A General Survey,” *CPHJ* 23, no. 4 (April 1932), p. 181.

Alongside broader distinctions between the experiences of urban and rural (or, in a sense, “civilized” and “primitive”) women, the bodies and births of Anglo-Canadian women were also routinely contrasted with those of their non-white counterparts in much of the professional medical discourse of the period. In the Canadian context, this meant that the increasingly painful labours of white women were most often held up against the experiences of Aboriginal women, whose decreased pain perception was often attributed to an inferior level of civilization.<sup>143</sup> In the eyes of many mainstream medical professionals, childbirth for Indigenous women, in other words, was seen as a natural process, while late-Victorian common sense held that white women experienced more pain in giving birth due to the relationship between civilization and sensitivity. Descriptions like the following, included in Fenwick’s 1889 *Manual of Obstetrics, Gynaecology, and Pediatrics*, are representative of the language used by many medical experts during this period:

The savage woman retires, it may be to the forest, and secluded even from her female companions brings forth her child, and perhaps in a few hours is sufficiently restored to attend to her own and her infant’s necessities, and speedily returns to her usually laborious occupation. While somewhat similar cases rarely occur in civilized society, still the difficulties and dangers of labor are exceedingly augmented as the indulgences and luxuries of life are multiplied.<sup>144</sup>

These accounts of the pains so-called “savage” women experienced in giving birth were fuelled by a growing body of anthropological literature available to Canadians in the late nineteenth and early twentieth centuries. Ethnographic representations of Indigenous

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<sup>143</sup> This rhetoric established and reinforced racial hierarchies. See Jasen, “Race, Culture, and the Colonization of Childbirth in Northern Canada.”

<sup>144</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 59-60.

cultures relied on, to a large extent, the same descriptions of primitive births. Reverend A.G. Morice, for example, writing at the same time as Fenwick, described the habits of the Dene women of Northern Canada as follows: “When a period of confinement arrived, the mother would be delivered of her child without the help of a midwife, in any place and under any circumstances – in her lodge or even while travelling, and apparently without pain.”<sup>145</sup> Taken together, these medical and ethnographical narratives became, to borrow John Hoberman’s term, a kind of “medical folklore” that revolved around an emphasis on the “hardiness” and vitality of Aboriginal peoples.<sup>146</sup>

In the late nineteenth century, a core component of this medical folklore involved a focus on the highly visible and easily differentiated birthing positions adopted by so-called “primitive” groups of women. This fixation was perhaps best encapsulated in an 1882 volume, *Labor Among Primitive Peoples*, authored by George J. Engelmann, Professor of Obstetrics at Missouri Medical College. Engelmann examined the birthing positions of those women “whose labor is governed by instinct and not by prudery or the laws of obstetrics,” and compared these with the postures adopted by those women “among civilized races of the present day.” He concluded that the adoption of an active, semi-recumbent, or inclined position had the most beneficial effects on the progress of birth.<sup>147</sup> As illustrated in Figure 2.1, Englemann found that many “North American

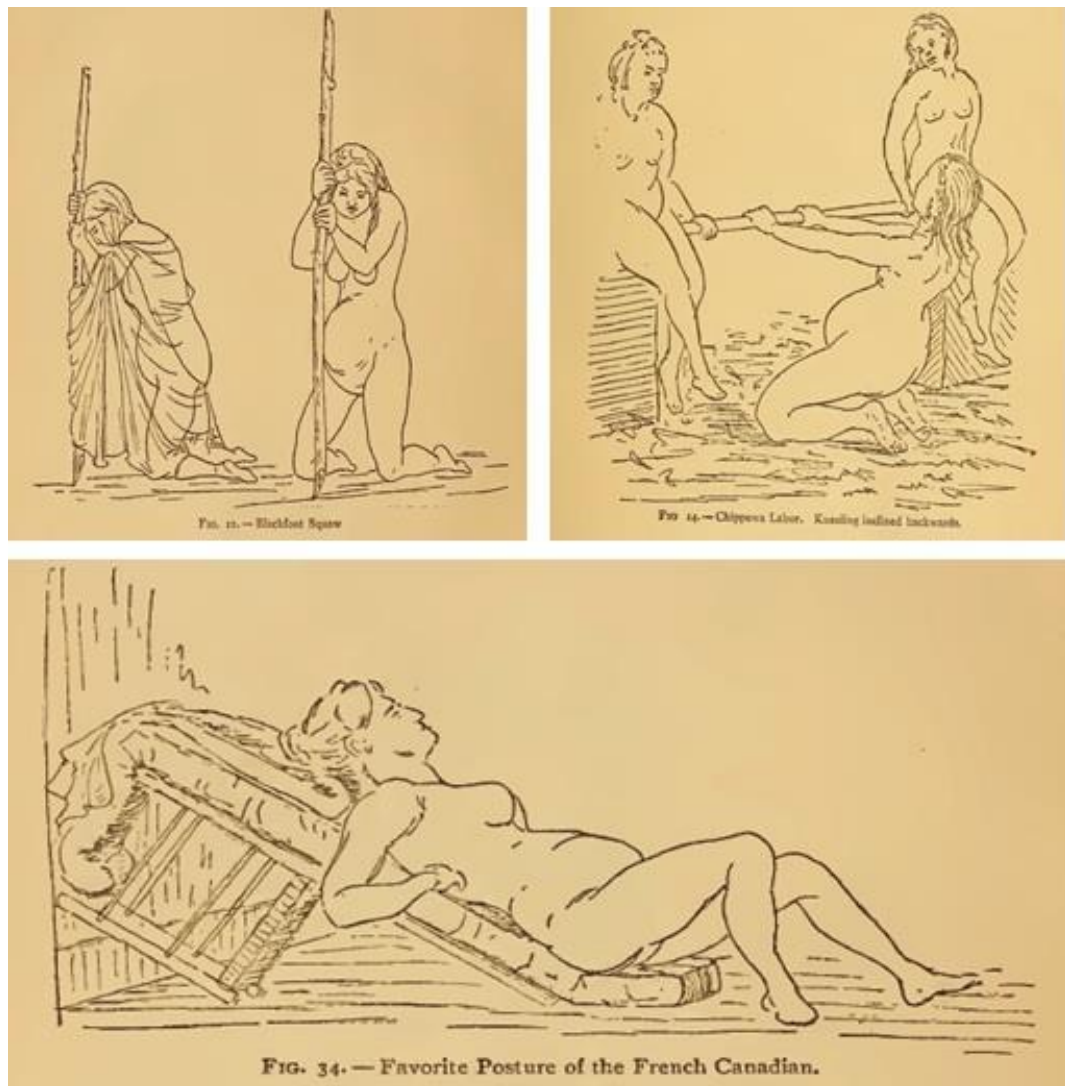
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<sup>145</sup> A.G. Morice, *The Western Denes, Their Manners and Customs* (Toronto: The Copp Clark Company, Limited, 1889), p. 126.

<sup>146</sup> While Hoberman argued that “a complex idea of black ‘hardiness’ and supernormal vitality” suffused American obstetric and gynaecological discourses during the nineteenth and twentieth centuries, I suggest that the same is true in terms of descriptions of Indigenous bodies and birth in the Canadian context. Hoberman, “The Primitive Pelvis,” p. 86.

<sup>147</sup> George J. Engelmann, *Labor Among Primitive Peoples: Showing The Development of the Obstetric Science of To-Day from the Natural and Instinctive Customs of All Races, Civilized and Savage, Past and Present* (St. Louis: J.H. Chambers, 1882), p. 6.

**Figure 2.1**



Top Left: The labour position of the “Blackfoot Squaw”. Top Right: Labour amongst the Chippewa. Bottom: Favorite posture of the French Canadian. George J. Englemann, *Labor Among Primitive Peoples: Showing The Development of the Obstetric Science of To-Day from the Natural and Instinctive Customs of All Races, Civilized and Savage, Past and Present* (St. Louis: J.H. Chambers, 1882), pp. 32, 37, 74. Not in Copyright.

Indians,” seeking “instinctively” to further labour, adopted kneeling or standing positions. Some, including those of the Chippewa (Ojibwe) nation, drew themselves up by seizing a horizontal pole during contractions. These “primitive” women, he asserted, rather than drawing on expert medical assistance, were more likely give birth attended by

“an old squaw, the recognized midwife of the camp, or a female relation.”<sup>148</sup> Adopting a posture more reminiscent of the British and American customs which saw women give birth lying on their backs or sides, Engelmann found that “Canadian French women are partial to an inclined plane, made by turning forward and downward a high-backed chair, pressing it back against the wall of the room, and making a bed upon it.” While such positions were comfortable for the parturient, Englemann lamented that in attending French Canadian patients, “the legs of the attendant suffer from the stooping posture necessary.”<sup>149</sup>

With these images and descriptions, Engelmann, like other physicians who emphasized these differences, established and perpetuated a double-edged hierarchy of women’s bodies and birth experiences. Though British and American birthing customs were held up as more “civilized” than the practices of the titular “primitive peoples” Engelmann discussed, the more instinctual postures were found to result in easier births, and fewer accidents and deaths in childbed.<sup>150</sup> Anthropological emphases on the birthing positions adopted by various Aboriginal peoples continued into the mid-twentieth century. By the early 1900s, however, physicians were beginning to comment that the study of such postures – dictated, as J. Clifton Edgar argued in his 1907 text, by “custom rather than instinct” – taught the medical practitioner “nothing of practical

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<sup>148</sup> Engelmann distinguished between “those who are partly civilized” and delivered atop “straw overlaid by quilts and blankets” and those “wild or blanket Indians” who spread dry grass on the ground ahead of the birth. Engelmann, *Labor Among Primitive Peoples*, pp. 32, 37.

<sup>149</sup> Engelmann, *Labor Among Primitive Peoples*, p. 74.

<sup>150</sup> Engelmann, *Labour Among Primitive Peoples*, p. 122. Throughout his work, Engelmann relied on generalized descriptions of the birth positions of different groups. He neglected to recognize, as Mitchinson has suggested, that throughout the late nineteenth century, many British and American-trained physicians allowed patients considerable freedom in choosing the position in which they gave birth. See Mitchinson, *The Nature of Their Bodies*, p. 198.

importance.”<sup>151</sup> Nevertheless, attention to the role of racial differences in shaping birth experiences persisted.<sup>152</sup>

In early twentieth century professional discourses, medical experts routinely emphasized a few key factors when explaining why so-called “primitive” women were less sensitive to the pains of giving birth. In a 1905 survey of “Ojibway Obstetrics” published in *Queen’s Medical Quarterly (QMQ)*, Dr. L.W. Jones summarized the most “valid and logical reasons” put forward by mainstream practitioners in the leading obstetric texts of the period: the “enfeebled vitality and poor muscular development of the woman of to-day,” “the wearing of corsets and tight lacing” which weakened modern women, and the fact that North Americans paid for their “high degree of development with a larger cranium in the infant, as contrasted, with, let us say, the Indian, and consequently greater pain in its passage through the birth canal.”<sup>153</sup> The bulk of medical experts during this period seem to have taken up this final point above the others, emphasizing the differences in head size between “civilized” and “savage” infants in a variety of popular medical texts and journal articles. Charles Reed explicitly stated that “savage women, as a rule, have but little difficulty in childbed, because they have large bodies, and bear children with small heads,” and singled out “the relatively large cranial

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<sup>151</sup> In her 1951 study, Anthropologist Mary Inez Hilger placed heavy emphasis on the kneeling position adopted by Chippewa mothers in giving birth. Mary Inez Hilger, *Chippewa Child Life and Its Cultural Background* (St. Paul: Minnesota Historical Society Press, 1951, 1992 Reprint), pp. 13-15. Edgar, *The Practice of Obstetrics*, p. 868.

<sup>152</sup> See, for example, Reed, *A Text-Book of Gynaecology*, p. 6; DeLee, *The Principles and Practice of Obstetrics*, p. 118, 132; and Davis, “Painless Childbirth,” *DMM* (1917), p. 80.

<sup>153</sup> L.W. Jones, “Ojibway Obstetrics,” *Queen’s Medical Quarterly (QMQ)* 10, no. 1 (October 1905), p. 25.

development of children born by civilized women,” above all other factors, as tending “to increase the difficulties and dangers of parturition.”<sup>154</sup>

Canadian practitioners made similar assertions. Smith, for example, offered an earlier iteration of Reed’s reasoning, but suggested that civilization had the particular effect of enlarging the heads of male infants.<sup>155</sup> Again, medical experts found these arguments reflected in the ethnographical research of the period. Benedictine nun and American anthropologist Mary Inez Hilger, for example, conducted fieldwork amongst the Chippewa during the 1930s. She observed that Chippewa mothers faced many cultural taboos concerning their conduct during pregnancy, and were often warned to curtail their food intake “since it made the baby large and birth difficult.” Eating fat, grease, and tallow, in particular, were thought to cause the child’s head to grow to a painful size. Chippewa women were also expected to perform manual labour throughout their pregnancies, based on the belief that such physically-demanding activities “kept the child loosened and made birth easy,” in addition to preventing the retention of the placenta.<sup>156</sup> Based on these factors, Aboriginal women were regularly seen by medical professionals and ethnologists alike as experiencing less pain during childbirth – an observation borne out, perhaps, in the ways in which Indigenous women and men framed the births that took place in their respective cultures.<sup>157</sup> Leading obstetricians also argued,

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<sup>154</sup> Reed, *A Text-Book of Gynaecology*, pp. 6, 10.

<sup>155</sup> Smith, “What Civilization is Doing for the Human Female,” *CMR* (1889), pp. 28-29.

<sup>156</sup> Hilger, *Chippewa Child Life and Its Cultural Background*, pp. 6-7, 9-10.

<sup>157</sup> Gilbert Abraham, a member of the Saulteaux Ojibwe Nation, who was born in Pine Falls, Manitoba in 1923, asserted a November 1985 interview that his time working at the Winnipeg General Hospital had taught him that “Indian people, they seem not to cry...when they’re in labour...we were taught, I suppose, not to cry...perhaps this is the reason the doctors would say that we are inhuman.” Interview with Gilbert Abraham, 22 November 1985, C-288, Winnipeg Past and Present Oral History Project, Archives of Manitoba. While birth customs varied widely amongst Indigenous cultures, Kim Anderson has demonstrated that several Aboriginal women did



however, that marginalized and racially-othered groups, including those women who could be classified as “primitive” or “less-educated,” simultaneously had the capacity to bear “a degree of suffering and straitened circumstances which would be intolerable to their more highly strong and sensitive sisters.”<sup>158</sup>

In the professional discourses that formed a key site of debate for Canadian practitioners, medical experts routinely argued that Aboriginal women experienced relatively little pain in parturition. By the early twentieth century, however, these racialized descriptions of bodily sensitivity became more nuanced. Whereas many medical experts had previously glorified the natural bodies and relatively painless births of Indigenous women, a new generation of practitioners seemed increasingly willing to point out the perceived drawbacks of “primitive” birth in both obstetric texts and professional periodicals.

In his 1908 volume, Emilius Clark Dudley, Professor of Gynaecology at Northwestern University Medical School complicated existing understandings of Aboriginal births by suggesting that “want of care, during and after labour” contributed to high rates of post-birth complications including uterine prolapse amongst these populations. Calling into question the absolute vitality and hardiness of Indigenous women, Dudley argued that “the educated woman could ‘resume the march’ [shortly after birth] if it were necessary...but education has taught her that this is unsafe.” As a result of these racial differences in terms of the accustomed lying-in period after birth, Dudley

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recall the stories of women giving birth alone when necessary. Many also recounted prenatal preparations undertaken in preparation for easier labours. Birth was largely seen as a natural event. Kim Anderson, *Life Stages and Native Women: Memory, Teachings, and Story Medicine* (Winnipeg: University of Manitoba Press, 2011), pp. 47-49.

<sup>158</sup> Fairbairn, *Gynecology with Obstetrics*, p. 670.

concluded that “the savage woman looks old and withered at thirty; the civilized women preserves something of youth until the age of fifty.”<sup>159</sup> Other physicians made similar statements. Hirst, for example, suggested that based on his discussions with those physicians attending American Indian reservations, he could confidently assert that “there is not a child-bearing woman over thirty-five whose womb is not hanging out of her body.”<sup>160</sup> Attention to growing rates of obstetric complications, gynaecological disease, and infant and maternal mortality amongst “the uncivilized races” increased throughout the first half of the twentieth century.<sup>161</sup> These medical discussions went hand in hand with ethnographical descriptions of the negative effects that modernity had on the bodies and births of Indigenous women throughout Canada.<sup>162</sup> Fundamentally, then, while so called “savage” women may have been seen to experience easier births – arguably, a

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<sup>159</sup> Emilius Clark Dudley, *The Principles and Practice of Gynaecology for Students and Practitioners*, 5<sup>th</sup> Edition (Philadelphia and New York: Lea & Febiger, 1908), pp. 27-28.

<sup>160</sup> Hirst, *A Text-Book of Obstetrics*, p. 224.

<sup>161</sup> DeLee, *The Principles and Practice of Obstetrics*, pp. 118, 132. Eden was careful to point out that “whether these women suffer more than others from the remote ill-effects of childbearing has not yet been shown.” As mainstream medical practitioners placed a very heavy emphasis on the pathological effects of childbirth for all women, this statement is not surprising, Eden, *A Manual of Midwifery*, p. 559.

<sup>162</sup> Rev. A.G. Morice argued that the changes the Dene had experienced in terms of “diet and mode of living” contributed to increasingly “painful accouchements,” as well as higher rates of stillbirth and maternal mortality, especially amongst “the most civilized of the four tribes.” Rev. John McLean similarly criticized the changes associated with modernity for destroying “the primitive virtue of Indian womanhood” and rendering Aboriginal mothers the “victims of premature old age.” Based on his experiences among “the pure-blooded Eskimos of the Northern Labrador” in the 1920s, Samuel King Hutton found that uterine inertia was “exceedingly common in child-birth among Eskimo women,” and, along with menorrhagia and stillbirth, was most common “where the Eskimos are most altered in their habits from the primitive habits of life and food.” Ethnologists suggested, then, that the changing lifestyle habits associated with modernity could have a negative impact on the bodies and birthing experiences of all races. Morice, *The Western Denes*, p. 126; John McLean, *The Indians: Their Manners and Customs* (Toronto: William Briggs, 1889), p. 26; John McLean, *Canadian Savage Folk: The Native Tribes of Canada* (Toronto: William Briggs, 1896), p. 193; Samuel King Hutton, *Health Conditions and Disease Incidence Among the Eskimos of Labrador* (London: The Wessex Press, 1925), pp. 19-20.

desirable trait – their bodies were nonetheless denigrated when compared with those of their so-called “civilized” counterparts.

Physicians made similar arguments about the births of other racialized groups of women. The recurrence of these discussions highlights, as Hoberman has suggested, that the “most fundamental dichotomy” in the construction of obstetrical hardiness and sensitivity to pain “is the distinction between the primitive and the civilized.”<sup>163</sup> Focusing on the American context, Hoberman was careful to point out that this was “not always a distinction between black and white.”<sup>164</sup> While Canadian practitioners were most often exposed to rhetoric that relied on descriptions of primitive Aboriginal bodies and births as a foil to emphasize the delicacy and “exquisite sensitivity” of Anglo-Canadian women, they did also encounter descriptions of black desensitivity. Writing in 1931, Williams, for example, described higher rates of contracted pelves among African American women, but argued that these groups still had lower rates of operative interference than their white counterparts “due to the fact that Negro children are somewhat smaller and have more compressible heads.”<sup>165</sup> Canadian physicians also argued, more vaguely, that based on observations one could conclude that “foreign-born women can seemingly stand much

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<sup>163</sup> The ways in which Canadian practitioners described evaluating and categorizing the bodies and births of various groups of women demonstrate that whether or not a woman could be categorized as “primitive” was often the most important factor. Based on his experiences practicing medicine in the 1920s, William Victor Johnston for example, discussed the “durability” of women during birth using the following examples of “the amazing strength of women in childbirth down through the ages in all parts of the world under the most trying conditions: the Eskimo mother who goes out on the ice alone to have her baby, the English women during the Middle Ages, and our own Canadian pioneer mothers.” Though the distinction could be made based on any combination of race, ethnicity, historical position, or mode of living, those women who could be cast as “primitive”, Johnston and others suggested, had easier labours. Johnston, *Before the Age of Miracles*, p. 40.

<sup>164</sup> Hoberman, “The Primitive Pelvis,” p. 87.

<sup>165</sup> Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 16.

more pain than those of Anglo-Saxon stock.”<sup>166</sup> As with many professional discussions focused on gendered experiences of health and reproduction during this period, medicalized descriptions of these differences often relied on analogies comparing the bodies of women and animals.<sup>167</sup> Alongside these metaphors, the growing prevalence of professional discussions about the dangers of “interbreeding” reflected mounting anxieties about racial mixing and miscegenation into the mid-twentieth century.

In the years following the First World War, the growing sense of unease about the health of the Anglo-Canadian race manifested in a variety of often unexpected ways, including professional medical discussions and debates about the pain various groups of women could be expected to experience in giving birth.<sup>168</sup> While these anxieties prompted medical experts to frame the relief of pain during labour as an increasingly pressing public health issue (see Chapters 3 and 4), they also found expression in discussions about the negative effects that interracial unions had on both society as a whole, and the bodies of individual mothers and children. In a 1928 article published in

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<sup>166</sup> F.W. Jackson, N.R. Rawson, and E. Couture, “Maternal Mortality in Manitoba,” *CPHJ* 31, no. 7 (July 1940), p. 320.

<sup>167</sup> In his 1905 article, Jones posed the question: “The lower animals beget their progeny with comparative immunity from pain and danger. Why, then, do our Caucasian women suffer the agonies incidental to motherhood?” Jones, “Ojibway Obstetrics,” *QMQ* (1905), p. 25. Other physicians made similar comparisons over the coming decades. See, for example, Berkley and Bonney, *The Difficulties and Emergencies of Obstetric Practice*, p. 578. Samuel Peikoff suggested that the experiences of rural Manitoba mothers, “often out in the field stacking sheaves of grain, or in the stable milking cows” only a day or two after giving birth reminded him of “the difference between a delicate race horse and a Clydesdale work horse. Tap the leg of the race horse lightly with a cane and he begins to limp. Yet I have seen a heavy Clydesdale with a three-inch gash go right on working.” He also recalled the comments of a patient’s husband, who took these animal analogies to a new level, likening his pregnant wife to other livestock he owned, and predicting her due date based on “dates of service.” Peikoff, *Yesterday’s Doctor*, p. 38.

<sup>168</sup> McLaren notes that these concerns were based on the widely-held perception that as “the ‘best’ young Canadians, according to English-Canadian writers, were going to their deaths Flanders...the ‘worst’ languished and reproduced at home.” McLaren, *Our Own Master Race*, p. 43.

the *CMAJ*, Kennedy McIlwraith of the University of Toronto argued that while medical experts had previously recognized that “the effects of miscegenation” were very marked, “rapid transport has made this a much more important factor in modern times.”

McIlwraith continued: “long ago if races mixed it was with a neighbouring race, and but little change was produced. But to-day races from all quarters of the earth meet and mix, especially in our new country.”<sup>169</sup> Into the 1930s, he discussed the negative effects of miscegenation or “intermarriage between different races,” citing this as a factor contributing to “difficult labor.”<sup>170</sup> While doctors like McIlwraith focused on the possibility that recent immigrants to Canada could contribute to racial decline, other medical experts alluded to the threat posed by intermarriage between Anglo-Canadians and Indigenous peoples. A survey of the maternal deaths in Manitoba between 1938 and 1940, for example, included the conclusion that “the death rate among the Half-breeds is very high.”<sup>171</sup> These eugenic concerns were a prevalent part of Canadian medical discourse throughout the period under study.

Alongside growing anxieties surrounding increasing immigration and the relatively high birth rates of immigrant populations compared to Canadians of Anglo-Saxon backgrounds, attention to the relationship between race and sensitivity to pain persisted throughout the interwar years. During these decades, medical perceptions of the impact of race on individual birth experiences – largely beginning as a series of motifs

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<sup>169</sup> McIlwraith, “The Obstetrician’s ‘Raison d’Etre’,” *CMAJ* (1928), p. 325.

<sup>170</sup> McIlwraith, “How to Reduce Maternal Mortality in the Province,” *CPHJ* (1931), p. 347.

<sup>171</sup> Women from a variety of British and European backgrounds were found to have the lowest mortality rates, ranging from 2.1 to 4.8 deaths per 1000 live births. For “Indians,” the rate was found to be 7.5 deaths per 1000 live births. For “half-breed mothers,” this jumped to 13.2 deaths per 1000 live births. Noel R. Rawson, “Maternal Deaths in Manitoba: The Findings of the Pregnancy Survey, 1938-1940,” *CPHJ* 32, no. 2 (February 1941), pp. 59, 65, 69.

based on select case examples and anthropological findings, and increasingly fuelled by popular stereotypes – were more and more borne out by “scientific” studies constructed to demonstrate and prove racial differences in sensitivity to pain.<sup>172</sup> A 1929 study published in the *CMAJ*, based on an analysis of patient case files from the Burnside Lying-In Hospital, concluded that “blue-eyed” women had longer labours than their “brown-eyed” counterparts, with an average duration of 17.6 hours compared to 10.5 hours, and bore children with longer (and, perhaps, it was inferred, larger) heads. For some, this provided seemingly concrete evidence that white, blue-eyed women had more difficult births than mothers belonging to a more racially-ambiguous, brown-eyed cohort.<sup>173</sup> Scientific attention to racial differences in sensitivity, both within and outside of the birthing room, continued into the mid-twentieth century. In 1943, Nova Scotian physician E. David Sherman concluded, based on an analysis of 450 cases, both that women had a lower threshold of pain than men, and, despite a limited Mi’kmaq sample size, that “Indians are a predominantly hyposensitive race.”<sup>174</sup> While the true effects of these perspectives on the relationship between race and sensitivity – increasingly supported by seemingly stable and objective medical science – are difficult to discern, these views went hand in hand with a broader lack of medical attention to the bodies and births of these supposedly “hardy” groups.

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<sup>172</sup> Hoberman, “The Primitive Pelvis,” pp. 90-91.

<sup>173</sup> Additionally, the majority of male children were born to blue-eyed mothers, with brown-eyed women found more likely to bear female children. Frank N. Walker, “The Influence of Head and Pelvic Harmony on the Duration of Labour,” *CMAJ* 20, no. 1 (January 1929), pp. 32, 35.

<sup>174</sup> E. David Sherman, “Sensitivity to Pain (With an Analysis of 450 Cases),” *CMAJ* 46, no. 5 (May 1943), pp. 437-441.

## Conclusion

The late nineteenth and early twentieth centuries marked a period of considerable social, cultural, and technological change throughout English Canada. During these decades, however, Canadian physicians consistently – and, arguably, increasingly – emphasized a recurring set of themes in their medical texts and professional journals. Medical practitioners routinely argued that different groups of women experienced different levels of pain in giving birth, citing perceived differences in class, mode of living, and racial or ethnic background as factors contributing to varying levels of sensitivity. At the same time, though, mainstream medical rhetoric held that the bodies, pregnancies, and births of all Canadian women were increasingly pathological, dangerously removed from their natural states due, in large part, to the growing pressures associated with modern life. Given the ongoing shortcomings of obstetric education, these messages – a prevalent feature in much of the professional medical discourse produced throughout this period – played a significant role in shaping the ways physicians approached the bodies and births of their parturient patients. For many Canadian practitioners, these ideas mandated growing levels of medical involvement and intervention in the birthing room, including, most notably, the provision of obstetric anaesthesia.

## **Chapter 3**

### **“By No Means A Unanimity of Opinion”:**

#### **Parturition and Pain Relief, c. 1870s-1930s**

The growing pathologization of female bodies, pregnancies, and births, discussed in the previous chapter, went hand in hand with medical ideas about the heightened pain “modern” women were expected to experience in bearing children. In late nineteenth and early twentieth century English Canada, this rhetoric mandated the increasing medical regulation of female bodies in a variety of ways, including, but not limited to, medical interventions in the birthing room. From the mid-Victorian period onwards, developments in the field of anaesthesia offered the possibility that pain no longer had to be the defining feature of birth experiences. Over the course of the transformative decades that followed, pain relief – both anaesthetic and analgesic – became a valuable tool used by physicians to exert control over their female patients. Alongside these developments, physicians gained new professional power and authority based on their expert ability to determine whether, and how much, their parturient patients should suffer. As those expectant mothers who could afford the increased costs associated with anaesthetized birth often sought out physicians who could offer pain relief, this was by no means a one-sided process. Fundamentally, however, the introduction of anaesthetics including chloroform and ether, did not simply provide physicians with new ways to manage pain: these substances offered them new ways to exercise their expertise and authority over the bodies of their female patients.

Taking a closer look at professional medical literature produced in late nineteenth and early twentieth century English Canada, this chapter offers an analysis of medical



discourses surrounding the use of anaesthesia in the birthing room. The first half of the chapter considers professional arguments for and against the use of obstetric anaesthesia. Medical experts asserted that, during the second half of the nineteenth century, there was “by no means a unanimity of opinion” on these matters, and physicians relied on a variety of arguments to dispute widespread or routine anaesthetization.<sup>1</sup> By the first decades of the 1900s, however, the majority of Canadian practitioners who expressed their views in medical texts and journals spoke in favour of the judicious use of analgesic or anaesthetic pain relief in confinement. Again, these physicians proffered a variety of arguments in making the case for the professional, physiological, and humanitarian needs to alleviate pain.

The legitimacy of obstetric anaesthesia was largely established by the turn of the twentieth century. As such, the second half of this chapter explores physicians’ professional discussions about how to best relieve the “birth pangs” of their parturient patients. Wendy Mitchinson has argued that the early twentieth century medical literature “is replete with articles by physicians relating their use of new, old, or combination pain relievers which they felt they had discovered or rediscovered.”<sup>2</sup> Though physicians relied on a variety of anaesthetic combinations to offer pain relief, I focus my attention on a few of the most popular options – chloroform, and ether – in addition to briefly highlighting the contentious history of “Twilight Sleep” in the first decades of the twentieth century. Physicians’ preferred methods of providing pain relief revealed much about broader perceptions of women’s corporeal experiences of childbirth – namely, what doctors

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<sup>1</sup> Lusk, *The Science and Art of Midwifery*, p. 228.

<sup>2</sup> Mitchinson, *Giving Birth in Canada*, p. 210.

thought to be the moment of greatest pain. In all of these discussions, physicians consistently emphasized the professional expertise and authority that allowed them – as opposed to “less qualified” practitioners including nurses and midwives – to offer anaesthetic relief from the pains of giving birth. These discourses, in addition to promoting medicalized hospital birth, did much to enhance the growing prestige of obstetrics.

### Debating Obstetric Anaesthesia

The second half of the nineteenth century saw profound changes in terms of both the medicalization of childbirth and the professionalization of obstetrics. Following the discoveries of chloroform and ether in the 1840s, the biblical pronouncement, “in sorrow shall thou bring forth children” was increasingly up for debate in the eyes of many physicians – both specialists in the emerging field of obstetrics and general practitioners alike.<sup>3</sup> By the late-Victorian period, earlier links between anaesthetized unconsciousness, immorality, and sexual impropriety had weakened, as British women who could afford the additional costs increasingly embraced anaesthesia.<sup>4</sup> This was especially the case after Queen Victoria gave birth to two children while under chloroform anaesthesia in the 1853 and 1857, events that did much to increase the respectability of anaesthetized birth throughout the western world. Nevertheless, debates over the relative pros and cons of

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<sup>3</sup> In the King James Bible, *Genesis 3:16* reads “Unto the woman he said, I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children; and thy desire shall be to thy husband, and he shall rule over thee.”

<sup>4</sup> Snow, *Operations without Pain*, p. 120. See also Stephanie Snow, *Blessed Days of Anaesthesia: How Anaesthetics Changed the World* (New York: Oxford University Press, 2008).

obstetric anaesthesia continued into the late nineteenth century.

### Arguments against Anaesthetization

In the decades preceding Confederation, British North American physicians, engaging with American and European medical debates, were quick to counter any potential religious objections to the use of anaesthesia in obstetric cases. At the invitation of the editor of the *British American Journal of Medical and Physical Science (BAJMPS)*, Reverend Abraham De Sola, Lecturer on the Hebrew Language and Literature at McGill University, authored a detailed three-part examination of the text of Genesis 3:16 and its relationship to the employment of anaesthetics in cases of labour. This series of articles was published in the *BJAMPS* in early 1850. Given that many potential objections to the use of anaesthesia in labour were “founded on certain words occurring in the 16<sup>th</sup> verse of the 3<sup>rd</sup> chapter of Genesis,” DeSola, at the behest of journal editors, aimed to critically analyze the language used in this particular passage of the Bible. He argued that “if it can be shown on scientific principles that the words have no such meaning as have been attributed to them by the translators of the Anglican version and others, the objections founded on them, must be considerably modified, if not entirely removed.”<sup>5</sup> Focusing on the meaning and translations of the word “sorrow” in this particular passage, and based on a thorough examination of Hebrew scriptural texts, De Sola suggested that “physical labour,” “toil,” “effort,” and especially “travail” were the more effective translations of

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<sup>5</sup> Abraham De Sola, “Critical Examination of Genesis III.16, Having Reference to the Employment of Anaesthetics in Cases of Labour, Part I,” *BAJMPS* 5, no., 9 (January 1850), p. 228.

the term.<sup>6</sup> He concluded that, provided the administration of anaesthesia did not interfere with the safety and welfare of mother or child – a result that would render the practice “wrong, unscriptural, and sinful” – the provision of pain relief with “the effect only of assuaging the pain or ‘sorrow’ resulting from the travail...is a good, proper, and scriptural practice.”<sup>7</sup> Furthermore, De Sola identified a pressing issue involved with literal interpretations of existing translations. Ideas about the innate relationship between birth and painful sorrow could not be taken literally. If they were, De Sola suggested, the devout accoucheur would be compelled to go so far as to cause pain – or as he put it, “to use such means that the labour should indeed be one of ‘sorrow’” – when attending the births of those women whose “more natural mode of life” led them to experience “little or no inconvenience from labour.”<sup>8</sup>

Published shortly after the first obstetric applications of anaesthesia in the late 1840s, De Sola’s early examination of the potential religious complications involved with such practices appears to have effectively curtailed any significant debate over the morality of anaesthetizing parturient patients. J.T.H. Connor has argued that De Sola’s conclusions had a broader impact, and perhaps “eased the consciences of certain physicians who might have wondered about the ethical and scriptural propriety of anaesthetics in midwifery.” Late-Victorian doctors, Connor suggested, would also be able to offer De Sola’s reasonings to their patients, “especially those who wished to be

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<sup>6</sup> De Sola, “Critical Examination of Genesis III.16, Part I,” *BAJMPS* (1850), p. 229, and Abraham De Sola, “Critical Examination of Genesis III.16, Having Reference to the Employment of Anaesthetics in Cases of Labour, Part II,” *BAJMPS* 5, no. 10 (February 1850), p. 262.

<sup>7</sup> Abraham De Sola, “Critical Examination of Genesis III.16, Having Reference to the Employment of Anaesthetics in Cases of Labour, Part III,” *BAJMPS* 5, no. 11 (March 1850), p. 290.

<sup>8</sup> Here, De Sola singled out “the Squaws of Canada” as a particular example. DeSola, “Critical Examinations of Genesis III.16, Part III,” *BAJMPS* (1850), p. 292.

anaesthetized but felt that they should not, owing to religious convictions.”<sup>9</sup> While it is difficult to gauge the impact these arguments had on the growing use of anaesthesia in the birthing room, it does seem that Canadian practitioners were relatively unwilling to take up or continue this debate in their professional discourses. By the early twentieth century, physicians made ready reference to the lack of grounds for any religious arguments against the use of anaesthesia. DeLee asserted in his 1913 text, *The Principles and Practice of Obstetrics*, that “objections [to the use of anaesthesia] on the score or religious scruples...need no comment.”<sup>10</sup> Canadian practitioners agreed, but also took the time to point out the illogical nature of such arguments.<sup>11</sup>

Despite the relative lack of religious-based objections, physicians continued to speak out against the use of anaesthetics in the birthing room. One of the most vocal opponents to obstetrical anaesthesia in the mid-nineteenth century was undoubtedly Charles Meigs, who opposed its use based on a variety of reasons. In an exchange with James Young Simpson that was included as part of his 1852 text, *Obstetrics: The Science and The Art*, Meigs suggested that despite the fact that he wished to avoid such topics entirely, he felt “constrained to overcome his reluctance” and address the issue of obstetric anaesthesia in his teachings to medical students and future practitioners.<sup>12</sup> Though he conceded that anaesthetization was necessary in “instances of severe suffering” in the birthing room, Meigs stated that he “remain[ed] as yet unconvinced” of the necessity of obstetric anaesthesia in the majority of cases, and opposed its routine use

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<sup>9</sup> Connor, “To Be Rendered Unconscious of Torture,” p. 39

<sup>10</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 293.

<sup>11</sup> See W.T. Hattie, “Anaesthesia in Early Days,” *CMAJ* 20, no. 5 (May 1929), p. 528.

<sup>12</sup> Meigs, *Obstetrics: The Science and The Art*, p. 364.

for three main reasons. First, he suggested that such a measure was unnecessary in “ordinary cases of parturition,” as, based on his own analysis, he estimated that the average parturient woman only “really suffer[ed] from labor pains about twenty-five minutes and no more.” This suffering, he noted, was distributed across the entire duration of labor. The widespread use of anaesthesia, Meigs suggested, was chiefly due to “an exaggerated notion of the nature of labor-pains.”<sup>13</sup> Second, Meigs argued that the so-called “friends of anaesthesia” were all too willing to cast the birthing room as a place of “harrowing distress,” filled with “shrieks of anguish and despair.” Such representations, he suggested, were inconsistent with “the general state of facts,” as Meigs asserted that the lying-in room was, “for most of the labor, a scene of cheerfulness and gaiety.”<sup>14</sup> Finally, Meigs advised the young practitioner, “before making up his mind upon this point... to make himself aware that the encephalon [brain] is a compound organ, or a compound bulbous nervous mass.” Pointing out the complexity of the brain, Meigs sought to impress upon the reader that it was exceedingly difficult for the medical man to gauge the true effects of anaesthetization: “In short,” he asserted, “there is no ascertained law of progression in the activity or power of the anesthetic agent...and no man knows, when he begins to administer the article, upon what part of the brain it will proceed to exert its benumbing power.”<sup>15</sup> Though Meigs was at the forefront of opposition to obstetric anaesthesia throughout the 1850s and 1860s, Canadian physicians appear to have taken the arguments he put forward, more generally, with a grain of salt. An 1863 review of his text in the *Canada Lancet* for example, described his observations on

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<sup>13</sup> Meigs, *Obstetrics: The Science and The Art*, p. 365.

<sup>14</sup> Meigs, *Obstetrics: The Science and The Art*, pp. 365-366.

<sup>15</sup> Meigs, *Obstetrics: The Science and The Art*, p. 366.

puerperal fever as “peculiar,” and those on the conduct of labour as “really rich – a single reading being worth alone the price of the whole work.”<sup>16</sup> While it is impossible to know how Canadian physicians interpreted this somewhat tongue-in-cheek assessment, it is likely that some practitioners, at least, were less than willing to adopt Meigs’ viewpoint when it came to the provision of anaesthesia.

Nevertheless, the medical profession as a whole continued to debate the relative merits and drawbacks of anaesthetizing parturient women. In 1888, William Thompson Lusk asserted that when it came to “the right of a woman to have her suffering assuaged in ordinary normal labor,” there was “by no means a unanimity of opinion” amongst physicians.<sup>17</sup> Alongside their British and American colleagues, Canadian practitioners continued to oppose the indiscriminate use of anaesthesia into the closing decades of the century, relying on a variety of arguments.

First, physicians spoke out on the diagnostic benefits of pain. Alongside broader discussions about the need for multi-sensory expert interpretations of the sights and sounds of childbirth (as discussed in Chapter 1), medical students were taught that close observation of their patients during the pains could provide a heightened understanding of the processes and pace of labour. Aside from being able to distinguish between “true” and “false” labour pains, practitioners were confident that “an experienced accoucheur” could determine whether or not the dilation of the cervix was complete “by observing whether the patient merely squeezes or presses the hands of her assistant, or, on the other hand, whether she pulls them with great violence.”<sup>18</sup> Such arguments were part of a more

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<sup>16</sup> “Review of *Obstetrics: The Science and The Art*,” *CL* 5, no. 1 (July 1863), p. 38.

<sup>17</sup> Lusk, *The Science and Art of Midwifery*, p. 228.

<sup>18</sup> Meigs, *Obstetrics: The Science and The Art*, p. 292.

extensive body of medical discourse, in which practitioners emphasized the broader utility of pain as a diagnostic tool for all female complaints. Dr. Ernest Hall of Victoria, British Columbia, commented in an 1898 article in *The Canadian Medical Review* that based on his experiences working in the field of gynaecology, he had concluded that “pain is a symptom of no little importance” for the medical practitioner. Furthermore, he suggested that individual experiences of pain had an enormous impact on how patients gauged their own health and any potential problems: “it is largely by the intensity of this symptom that our patients measure the gravity of their complaints.”<sup>19</sup> Pain, for many practitioners, was seen to have diagnostic significance for both the patient and the physician, existing as an important and valuable signifier of bodily distress or the onset and progress of labour. At the same time, some suggested that pain was a core physiological component of labour’s progress, and argued against the use of obstetric anaesthesia – and, accordingly, the alleviation of pain – for this reason.

In their lectures and medical texts, late nineteenth century physicians and medical educators often emphasized the belief that pain was a physiologically necessary part of labour. Meigs, for one, wrote that he viewed labour pains as “a most desirable, salutary, and conservative manifestation of life-force.” Provided that the parturient was carefully “sustained by cheering counsel and promises and freed from the distressing element of terror,” Meigs found that the patient in the birthing room “could in general be made to endure without great complaint.”<sup>20</sup> Physicians placed particular emphasis on the physiological value of pain during the second stage of labour. Here, they described each

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<sup>19</sup> Ernest Hall, “The Significance of Pain in Gynaecological Diagnosis,” *TCMR* 8, no. 3 (September 1898), pp. 67-68.

<sup>20</sup> Meigs, *Obstetrics: The Science and The Art*, p. 373.



pain, and the subsequent advance and recession of the infant head, as the impetus and defining feature of the birthing process. Practitioners noted that following the delivery of the head, “a single pain” was generally sufficient to bring about the birth of the rest of the infant’s body.<sup>21</sup> Canadian physicians also emphasized the role of pain as the physiological driving force in labour. Kenneth Neander Fenwick, for example, placed pain at the centre of his 1888 description of the second stage, writing that as pains intensified, “the head now makes progress, the perineum bulges, the labia gapes, the head recedes during the interval and then advances during the pain.”<sup>22</sup> Throughout the late nineteenth and early twentieth centuries, however, many physicians used the term “pain” in a way that was synonymous with uses of the term “contraction.” As will be discussed later in this chapter, those who supported the use of obstetric anaesthesia relied on the distinction between the two terms in making the case for pain relief during labour.

Late nineteenth century physicians argued that pain also provided the medical practitioner with a unique opportunity for examination, and accordingly, information and potential diagnosis. At mid-century, Meigs had encouraged his students to “seize” the opportunities offered by contractions to make a digital examination of their expectant patients. By carrying out examinations at this particular and painful moment – a practice Meigs referred to as “taking a pain” – medical expertise held that the patient’s mind would be “somewhat diverted from the awkwardness of the situation.” As a result, both the physician and the patient were spared “unnecessary levels of embarrassment.”<sup>23</sup>

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<sup>21</sup> See also Lusk, *The Science and Art of Midwifery*, p. 140.

<sup>22</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 44.

<sup>23</sup> Meigs, *Obstetrics: The Science and The Art*, p. 297. Meigs cautioned his students not to make use of instruments during a pain, advising that to avoid contusion or laceration in forceps cases,

Writing two decades later, William Smoult Playfair echoed this argument, noting that though the examination needed to be completed in the interval between pains, its commencement during a pain rendered the ordeal “less distressing to the patient.”<sup>24</sup> Lusk recommended that both manipulations and episiotomies should always be performed during a pain, but recognized the need to provide anaesthesia during these maneuvers.<sup>25</sup> This caveat suggests that Lusk, like many physicians during this period, was using the term “pain” interchangeably with the term “contraction,” making physical discomfort secondary to the involuntary efforts of the uterus. Relying on the same line of reasoning, doctors arguing against the use of anaesthesia also suggested that its use would lead to snowballing interventions in the birthing room. Forceps, in particular, were seen by nineteenth century practitioners as substitutes for labour pain and the natural forces.<sup>26</sup>

Finally, late nineteenth century opponents of anaesthetization relied on a variety of conservative arguments that emphasized maternity as a woman’s highest purpose. As part of his broader and vocal opposition to the widespread use of anaesthesia in the birthing room, Meigs expressed his belief that the pain of giving birth went hand in hand with a “violent excitement of the nervous and circulatory systems,” which, once resolved by “cries of joy, by tears, and by the delightful sense of security, triumph, and finished toil,” resulted in “that gushing tenderness which a mother feels for her new-born and helpless progeny.”<sup>27</sup> For Meigs, then, pain was a necessary precursor to the formation of

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“all action ought to be suspended until the pain has ceased.” Meigs, *Obstetrics: The Science and The Art*, p. 547.

<sup>24</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 255.

<sup>25</sup> Lusk, *The Science and Art of Midwifery*, pp. 199, 218.

<sup>26</sup> Meigs, *Obstetrics: The Science and The Art*, p. 577; Bedford, *The Principles and Practice of Obstetrics*, p. 577.

<sup>27</sup> Meigs, *Obstetrics: The Science and The Art*, pp. 313-314.

the all-important emotional bond between mother and child. Gunning Bedford took a different approach to argue against the administration of anaesthesia during “the most interesting period” of a woman’s life. The expectant mother, he asserted, “should, all other things being equal, have her mind unclouded, her intellect undisturbed, [and] her judgement fully adequate to realize and appreciate the advent of a new and important era in her existence – the birth of her child.”<sup>28</sup> The significance of maternity remained a recurring theme in arguments both against and in favour of obstetric anaesthesia.

By the closing decades of the nineteenth century, views such as Meigs’ were increasingly overshadowed by growing number of arguments in favour of offering pain relief to parturient patients. Writing in 1876, the British obstetrician William Smoult Playfair described obstetric anaesthesia as “a practice which has become so universal that no argument is required to establish its being a perfectly legitimate means of assuaging the sufferings of childbirth.”<sup>29</sup> By 1878, another popular text, Thomas’ *Notes from Lectures on Obstetrics*, cautioned practitioners to “always get the patient’s permission” before administering anaesthesia, suggesting that, for some, its use in obstetric cases had become largely a matter of routine.<sup>30</sup> Despite these shifting professional debates, the decision of whether or not to employ an anesthetic was still very much an individual one, varying according to the experience and preference of the individual practitioner.<sup>31</sup> Wendy Mitchinson has argued, however, that most Canadian physicians “were more than willing” to provide anaesthesia to their patients by the turn of the twentieth century.<sup>32</sup>

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<sup>28</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 712.

<sup>29</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 266.

<sup>30</sup> Thomas, *Notes from Lectures on Obstetrics*, p. 31.

<sup>31</sup> For more, see Connor, “To Be Rendered Unconscious of Torture,” p. 172.

<sup>32</sup> Mitchinson, *Giving Birth in Canada*, p. 207.

## Arguments in Favour of Pain Relief

As the twentieth century opened, a growing number of Canadian physicians spoke out in favour of the regular use of anaesthetics in the birthing room. Frederick Fenton, an Associate in the Department of Obstetrics at the University of Toronto, for example, argued in 1908 that “the routine use of anaesthetics where pains are even moderately severe, throughout both the first and second stage, should, I believe be as much a part of our technique in these cases as...the sterilizing of instruments before use.”<sup>33</sup> Into the interwar period, Canadian practitioners, drawing on arguments put forward in the British and American medical press, enthusiastically recognized “the advantageous influence exerted by the employment of anaesthetics in labour.”<sup>34</sup> By the 1930s, physicians increasingly expressed the belief that “in obstetrical practice, it should be an axiom that pain should be relieved in every case when it does not interfere with the safety of the child,”<sup>35</sup> and recognized that “all intelligent women” demanded “to be spared as far as possible from the suffering incident to the completion of normal labor.”<sup>36</sup> In a 1923 piece published in the *CMAJ*, Ross Mitchell, Associate Professor of Obstetrics at the University of Manitoba argued that the advantages of anaesthesia were “threefold in character,” obstetrical, physiological, and humanitarian.<sup>37</sup> As physicians’ arguments in favour of anaesthesia – throughout the late nineteenth and early twentieth centuries – can be broadly classified along these lines, it makes sense to discuss each of these categories, in turn.

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<sup>33</sup> Frederick Fenton, “Obstetrical Technique,” *CJMS* 24, no. 2 (August 1908), p. 69.

<sup>34</sup> A.D.B. “Anaesthesia During Childbirth,” *CMAJ* 23, no. 4 (October 1930), p. 564.

<sup>35</sup> McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 21.

<sup>36</sup> Williams, *Obstetrics: A Textbook for Students and Practitioners*, p. 386.

<sup>37</sup> Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* (1923), p. 718.

Alongside broader tensions surrounding the professionalization and modernization of obstetrics, turn-of-the-century physicians argued that the anaesthetization of parturient patients had a positive impact on the obstetrical work performed by the medical practitioner. Praising the benefits of “timely interference” and the performance of various manipulations or versions in difficult or pathological cases – a classification increasingly applied to the births of a growing number of white, middle-class women – physicians suggested that it was “hardly necessary to point out how much these manoeuvres will be facilitated by placing the patient fully under the influence of an anaesthetic.”<sup>38</sup> Anaesthetization, medical experts argued, also made for the easier use of instruments of all types. In contrast to his advice to “always get the patient’s permission” before administering anaesthesia, Theodore Gaillard Thomas suggested the opposite to the young practitioner when it came to the use of instruments, and pointed out the benefits of pain relief in allowing the physician to complete his work: “Never tell the woman you are going to use instruments. Give anaesthesia.”<sup>39</sup> Writing decades later, leading Canadian obstetrician Adam Wright pointed out that the anaesthetization of women during the use of forceps, in particular, was “not especially to prevent pain, but to keep the patient quiet during manipulation.”<sup>40</sup> This would, of course, make the physician’s work easier. Well into the twentieth century, Canadian practitioners continued to argue that fundamentally, the chief obstetric advantages of anaesthetization

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<sup>38</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, pp. 314, 266, 400.

<sup>39</sup> Thomas, *Notes from Lectures on Obstetrics*, p. 76.

<sup>40</sup> Wright, *A Text-Book of Obstetrics*, p. 557.

were the opportunities it offered the accoucheur “to make a clearer diagnosis, to have a more manageable patient, and to be able to preserve a better surgical technique.”<sup>41</sup>

Aside from benefitting obstetrical practice and technique, practitioners also argued that the administration of anaesthetics in the birthing room had a host of physiological advantages for the parturient patient. The first set of arguments emphasizing the physiological benefits of pain relief relied on, as previously suggested, the careful distinction between “pain” and “contraction” when it came to understanding the progress of labour. By the closing decades of the nineteenth century, physicians were careful to explicitly emphasize that removing pain would not necessarily delay delivery. In his 1889 text, Fenwick challenged what he saw as recurring assumptions that physical pain was the driving force behind “the expulsive stage of labour.” He argued that the fact that deliveries were completed “under anaesthesia, or in paraplegia,” coupled with the observation that in cases of uterine inertia “no amount of voluntary action of the abdominals will expel the child or arrest hemorrhage,” provided “sufficient proof” for the conclusion that pain, or even the conscious cooperation of the patient, was not a requirement for birth.<sup>42</sup> In his 1907 text, intended for nurses, Joseph Brown Cooke made the same distinction: “Labor-pains are merely the contractions of the uterine muscle, and are called ‘pains’ because of the suffering that accompanies them. The incorrectness of the term is evident when one occasionally hears a woman say, ‘I always have easy labors;

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<sup>41</sup> Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* (1923), p. 718.

<sup>42</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 48-49. This rhetoric, again, casts the parturient body as a machine, efficiently managed by the physician who acts as “foreman,” overseeing the labour process. See Martin, *The Woman in the Body*, p. 63.

my *pains* never hurt me at all.”<sup>43</sup> Physicians continued to emphasize this distinction throughout the first decades of the twentieth century.<sup>44</sup>

Based on this understanding, then, doctors were free to argue that the careful administration of anaesthesia for pain relief could do much to relax women and aid the physiological progress of birth. During the late nineteenth century, students were taught that anaesthetics including chloral, capable of producing a drowsy state without diminishing the power of uterine contractions, could be of particular value during the first stage of labour for those patients “in which the pains produce tolerably acute suffering but with little effect on the progress of labour.”<sup>45</sup> Edgar argued in his 1907 text that the administration of anaesthesia was “frequently useful in aiding the progress of labor, especially in the case of nervous and sensitive women who are badly affected by the pains, and in cases in which the contractions, while very painful, have but little power and in which the uterus does not relax between the pains.”<sup>46</sup> Writing in 1912, Barton Cooke Hirst offered an additional explanation, noting that in “hyperesthetic women,” the uterine contractions had the potential to “be so exquisitely painful that their first onset is followed by an inhibitory impulse which cuts them short almost immediately.”<sup>47</sup> Removing pain, Hirst held, would allay this inhibitory effect, allowing labour to progress. Additionally, as Joseph B. DeLee suggested, partial anaesthesia had the advantage of assuaging the pains of those “hypersensitive women” who refused to bear down during

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<sup>43</sup> Cooke, *A Nurse's Handbook of Obstetrics*, p. 141.

<sup>44</sup> See Davis, “Painless Childbirth,” *DMM* (1917), p. 80.

<sup>45</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, pp. 266-267. See also Thomas, *Notes from Lectures on Obstetrics*, p. 31.

<sup>46</sup> Edgar, *The Practice of Obstetrics*, p. 865.

<sup>47</sup> Hirst, *A Text-Book of Obstetrics*, p. 473.

the second stage of labour “because it hurts too much.” Anaesthesia had the effect of strengthening and permitting the action of the abdominal muscles, thereby allowing women to cooperate with physicians during the birthing process.<sup>48</sup> These arguments about the physiological benefits of anaesthesia, in terms of its effects on the progress of labour, continued into the interwar period.<sup>49</sup>

Emphasizing a related concept, Canadian physicians also suggested that the provision of anaesthesia had the additional effect of reducing the risk of perineal tear for the parturient woman. At a 1907 meeting of the London Medical Society, Dr. J. McArthur argued that the administration of chloroform during the second stage of labour, “beginning ...when the vertex touches the pelvic floor or bulges the perineum with every pain,” had the effect of abolishing discomfort and “paralyz[ing] the abdominal muscles.” With the patient rendered unable to bear down, McArthur suggested, the risks of perineal injury were lessened.<sup>50</sup> Those physicians in attendance agreed, and during the discussion of McArthur’s paper, chloroform was proclaimed an “important safeguard” to preventing rupture.<sup>51</sup> During the 1930 joint meeting of the British and Canadian Medical Associations, Dame Louise McIlroy made the same point, arguing that anaesthetization provided the physician with greater control during delivery, and accordingly, diminished the risk of lacerations.<sup>52</sup> Despite these arguments, however, rates of episiotomy, along with other obstetrical interventions, were on the rise alongside the broader medicalization and pathologization of childbirth. Writing in 1924 and assessing the state of Canadian

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<sup>48</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 570.

<sup>49</sup> See Mcilroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 24.

<sup>50</sup> McArthur, “Care of the Perineum in Connection with Labor,” *DMM* (1907), p. 117.

<sup>51</sup> McArthur, “Care of the Perineum in Connection with Labor,” *DMM* (1907), pp. 121-122.

<sup>52</sup> McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 24.



obstetrics, Herbert Little noted that “since 1906, median episiotomy has been practiced more or less frequently; indeed, since 1914 it has become practically routine with all primiparae.”<sup>53</sup>

Throughout the late nineteenth and early twentieth centuries, medical professionals placed significant emphasis on the physiological dangers of exposure to excessive levels of pain, especially if prolonged. These dangers were seen to extend to obstetric cases, and accordingly, physicians emphasized the damaging effects that exceedingly painful confinements could have on the health and bodies of their parturient patients. Noting that “some degree of nervous shock or exhaustion” was experienced as a result of most births, Playfair argued that “its amount is in proportion to the severity of the labor and the susceptibility of the patient; and it is, therefore most likely to be excessive in women who have suffered greatly from pain, who have undergone much muscular exertion, or who have been weakened from undue loss of blood.”<sup>54</sup> Writing in the late 1880s, Lusk suggested that in pathological cases, particularly when the pains or contractions were not contributing to the efficient progress of labour, “it is the element of pain which is most to be dreaded.” He continued: “Pain long continued is a powerful nerve-depressant. When combined with starvation and deprivation of sleep, it greatly impairs a woman’s capacity to resist the perils of the puerperal period.”<sup>55</sup> Practitioners continued to emphasize this relationship between heightened pain and increased susceptibility to post-birth infection into the early twentieth century.<sup>56</sup>

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<sup>53</sup> Little, “An Address on Obstetrics during the Past Twenty-Five Years,” *CMAJ* (1924), p. 906.

<sup>54</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 475.

<sup>55</sup> Lusk, *The Science and Art of Midwifery*, p. 452.

<sup>56</sup> See Hirst, *A Text-Book of Obstetrics*, p. 473, McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 22.

Canadian physicians also contributed to these arguments. In the late nineteenth century, Fenwick suggested that heightened pain during the second stage of labour could pose a danger to the vascular and nervous systems. He recommended that chloroform be administered in those cases where “pains are exhausting.”<sup>57</sup> Relying on observations from his own practice, Adam Wright emphasized the physiological dangers of shock, and concluded that “severe pain sometimes kills in a very short time.”<sup>58</sup> He recounted the following case, in particular, as evidence of “the great danger which sometimes arises from extreme pain”:

Primipara. An educated, refined, and somewhat delicate and small woman, graduate of the Toronto General Hospital Training School for Nurses, married to a physician living in Ontario. Came to Toronto for her accouchement, and was staying at the house of a friend before coming into a private ward at the Burnside. The membranes ruptured one morning, without warning, and she went at once to the hospital. Walked about a great deal during the day with the hope of bringing on labor pains. The following day she did more walking, until she became weary, and yet no pains appeared. At about eight in the evening she was lying on a couch but got up somewhat hurriedly and went into the next room to look for something she wanted. She was seized with severe pains...I was sent for but did not reach the hospital until nearly ten o'clock. I found the patient exhausted, and suffering so terribly I feared she would go into convulsions...I ordered chloroform to be administered to the surgical degree as rapidly as possible while I was preparing. I introduced first fingers, then the whole hand...applied the forceps and delivered, operation being completed at eleven o'clock. The patient made a good recovery.<sup>59</sup>

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<sup>57</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 44, 64.

<sup>58</sup> Wright, *A Text-Book Of Obstetrics*, p. 340.

<sup>59</sup> Wright, *A Text-Book of Obstetrics*, p. 318.

Here, Wright saw anaesthesia as allowing for greater intervention by the physician, but also, more importantly, as an aid in sparing this particular patient – an educated, refined, middle-class, “delicate little woman” – from the physiological effects of the “terrible nerve storm” that was an unnaturally painful birth.<sup>60</sup> Anaesthetized birth, then, made difficult motherhood easier for this particular group of women, who were often seen as the figurative mothers of the Anglo-Canadian race.<sup>61</sup> The pronatalist benefits of anaesthesia became all the more significant in the face of declining Anglo-Saxon fertility, rising immigration, and the growing prevalence of eugenic theories in the years surrounding the First World War.<sup>62</sup>

Canadian obstetricians argued that heightened pain during birth was also a leading factor contributing to puerperal mania or postpartum insanity.<sup>63</sup> Fenwick, for example, suggested that “acute delirium” was most likely to be observed “just when the suffering is most intense.” He noted that such conditions, however, “should rarely be seen in these days of anaesthetics.”<sup>64</sup> Again, some women were seen to be more at risk than others. Late nineteenth and early twentieth century physicians argued that “women of the gracile type, the highly polished output of our finishing schools, with one or several generations of overcivilized ancestors,” were more sensitive to “nervous exhaustion” or “the shock of

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<sup>60</sup> Wright, *A Text-Book of Obstetrics*, p. 318.

<sup>61</sup> See Comacchio, *Nations Are Built of Babies*, pp. 64-92. See also Mariana Valverde, “‘When the Mother of the Race is Free’: Race, Reproduction, and Sexuality in First-Wave Feminism,” in *Gender Conflicts: New Essays in Women’s History*, eds. Franca Iacovetta and Mariana Valverde (Toronto: University of Toronto Press, 1992), pp. 3-26.

<sup>62</sup> McLaren, *Our Own Master Race*, pp. 29, 47. Canadian birth rates had declined from 7.02 children per woman in 1851 to a “meagre” 3.54 in 1921. Roderic Beaujot and Kevin McQuillan, “Social Effects of Demographic Change: Canada, 1851-1981,” *Journal of Canadian Studies* 21, no. 1 (Spring 1986), pp. 57-59.

<sup>63</sup> For more on the history of puerperal mania see Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004).

<sup>64</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, pp. 124-125.

hard labor.” This nervous exhaustion was routinely framed as an “exciting cause” of puerperal mania.<sup>65</sup> Into the interwar period, medical experts continued to argue that “the abolition of anxiety and suffering,” via the provision of anaesthetic pain relief during birth, had the potential to circumvent puerperal insanity.<sup>66</sup> With the pain of giving birth removed, physicians argued parturient women could return to their natural state of passive femininity.<sup>67</sup>

Drawing on this series of arguments, physicians fundamentally suggested that the pain of labour placed parturient women at risk for shock and other physiological conditions that were, many argued, “more dangerous than the proper use of any of the analgesics now employed.”<sup>68</sup> Deaths during or immediately after childbirth – including, for example, in women with previously unknown or undiagnosed cardiac conditions – could be directly attributed to pain.<sup>69</sup> These ideas suffused medical practice into the mid-twentieth century, and represented the perspectives of other medical professionals, namely nurses, in addition to those of physicians. In 1946, Canadian physician A.D. Campbell drew parallels between obstetric shock and surgical shock in a text co-authored with nursing supervisor Mabel Shannon, and expressed what appeared to be a widely

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<sup>65</sup> Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 239. See also Edgar, *The Practice of Obstetrics*, p. 668, Hirst, *A Text-Book of Obstetrics*, p. 476, DeLee, *The Principles and Practice of Obstetrics*, p. 706.

<sup>66</sup> McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 22.

<sup>67</sup> Hirst argued that upon the termination of labour, for example, “the woman becomes perfectly quiet and composed, no matter how noisy she may have been before. The passive pleasure of relief from suffering is so great that it becomes a positive enjoyment simply to be quiet, and the woman does not wish to be disturbed.” Hirst, *A Text-Book of Obstetrics*, p. 180.

<sup>68</sup> Carl Henry Davis, *Painless Childbirth Eutocia and Nitrous Oxid-Oxygen Analgesia* (Chicago: Forbes and Company, 1916), p. 55.

<sup>69</sup> Herbert M. Little described two such cases at Montreal Maternity Hospital during the first decade of the twentieth century. Little, “On Death and Disability Resulting from Childbirth,” *CMAJ* (1911), p. 127.

held belief: “early and constant relief from pain is reflected in a smoother convalescence.”<sup>70</sup>

Finally, early twentieth century physicians also argued that, aside from negatively impacting the health of the mother, heightened pain during birth could have deleterious consequences for the health of the child. In the context of growing panics surrounding both maternal and infant mortality in the years following the First World War, practitioners may have found these arguments to be especially effective in making the case for obstetric anaesthesia.<sup>71</sup> Medical experts observed that cases where the parturient patient was permitted “to remain in constant pain and without sleep for twenty-four hours or longer” were more likely “to terminate fatally.”<sup>72</sup> Additionally, physicians argued that the shock that accompanied the majority of exceedingly painful deliveries had adverse effects on the production of breastmilk.<sup>73</sup> Again, these arguments would have been all the more powerful given public health concerns about the relationship between artificial feeding and infant mortality amongst Canada’s working classes.<sup>74</sup> Heightened levels of pain during childbirth, then, could be seen as having a marked negative impact on both mother and child alike. These arguments effectively transformed the provision of anaesthesia during birth into a public health issue, and as it concerned the health of Canadian children, a matter of national interest.

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<sup>70</sup> Campbell and Shannon, *Gynaecology for Nurses*, pp. 220-221, 228.

<sup>71</sup> For more on Canadian campaigns to combat infant and maternal mortality see Comacchio, *Nations are Built of Babies*.

<sup>72</sup> Eden, *A Manual of Midwifery*, p. 444.

<sup>73</sup> Davis, *Painless Childbirth Eutocia*, p. 132.

<sup>74</sup> Comacchio, *Nations are Built of Babies*, pp. 43-50.

Aside from arguments about the obstetrical and physiological advantages of anaesthesia, physicians also weighed in on their duty, based on humane grounds, to provide pain relief to their parturient patients. Not surprisingly, one of most vocal early supporters of obstetric anaesthesia was Simpson himself. Responding to Meigs' criticisms of anaesthetization in an 1848 letter, Simpson castigated those physicians who argued against the anaesthetic relief of birth pangs and allowed "their medical prejudices to smother and overrule the common dictates of their profession, and of humanity." He concluded that he had no doubt that those practitioners who "most bitterly" opposed the use of anaesthesia would be "yet, in ten or twenty years hence, amazed at their professional cruelty."<sup>75</sup>

Indeed, arguments about the need to provide pain relief in the birthing room based on humanitarian principles gained momentum over the subsequent decades.<sup>76</sup> By the early twentieth century, Canadian physicians suggested that a humanitarian standpoint provided "ample justification" for providing anaesthetics to laboring women.<sup>77</sup> During a paper presented at the 1916 annual meeting of the Ontario Medical Association, Toronto doctor J.A. Kinnear argued that physicians had a "duty" to relieve, for their obstetric patients, "as much of the pain and horror of labor as is consistent with the safety of mother and babe."<sup>78</sup> Physicians continued to emphasize these points into the interwar period, arguing that the need to relieve "the agony suffered by parturient women...should

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<sup>75</sup> Letter from James Young Simpson to Charles Meigs, 23 January 1848, Meigs, *Obstetrics: The Science and The Art*, p. 370.

<sup>76</sup> See, for example, Edgar, *The Practice of Obstetrics*, p. 865.

<sup>77</sup> Fenton, "Obstetrical Technique," *CJMS* (1908), p. 69.

<sup>78</sup> J.A. Kinnear, "The Use of Morphine and Hyoscine in Obstetrics," *DMM* 47, no. 4 (October 1916), p. 55. See also Mitchell, "Anaesthesia and Analgesia in Labour," *CMAJ* (October 1923), p. 718.

appeal to every humane individual in the medical profession.”<sup>79</sup> By the mid-1930s, Canadian practitioners asserted that it was a breach of “one’s duty as an obstetrician” and “inexcusable” not to attempt to alleviate women’s sufferings during labour.<sup>80</sup> These arguments went hand in hand with changing medical views of the nature of pain, increasingly framed as something to be relieved – or, in the words of Dalhousie University Professor of Histology D. Fraser Harris, a “sensation whose existence we desire to terminate” – in all cases.<sup>81</sup> At the same time, lay Canadian perceptions of anaesthetization were also changing. By the 1920s, physicians argued that the Canadian public had, generally speaking, “lost much of the dread with which it formerly viewed the temporary loss of consciousness” associated with anaesthesia.<sup>82</sup> In this atmosphere, medical practitioners took advantage of a host of available drugs and methods to offer pain relief to their parturient patients

#### The Most Agreeable Agent: Choosing and Administering an Anaesthetic

By the turn of the twentieth century, arguments against the use of anaesthesia during confinements were largely outweighed by those in favour of the provision of pain relief. As a result, a growing number of Canadian physicians were willing to offer pain relief to their expectant patients. This increased willingness to provide anaesthesia went

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<sup>79</sup> McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 26.

<sup>80</sup> Frank S. Brien, “Sedative Drugs in Obstetric Practice,” *UTMJ* 12, no. 12 (December 1934), p. 47.

<sup>81</sup> D. Fraser Harris, “Some Physiological Aspects of Referred Pain,” *CMAJ* 2, no. 4 (April 1912), p. 1.

<sup>82</sup> W. Webster, “An Address on the Effect of Anaesthetics on the Body as a Whole,” *CMAJ* 17, no. 11 (November 1927), p. 1294.

hand in hand with increasingly pathological views of the bodies, pregnancies, and births of “modern” women, as discussed in the previous chapter. Despite the growing trend towards anaesthetized birth, physicians continued to engage in professional debates over the best drugs and methods to offer relief to their anaesthetized patients.<sup>83</sup> Historians have argued that attempts to make sweeping generalizations about the dominance of one anaesthetic agent in late nineteenth and early twentieth century Canada should be guarded, as the medical profession remained in a state of flux.<sup>84</sup> Indeed, the regular use of one type of anaesthesia over others varied from physician to physician, as individual preferences were shaped by both training and regional patterns.<sup>85</sup> Nevertheless, a historical examination of professional discourses does suggest the emergence of certain trends when it came to the provision of obstetric anaesthesia.

Throughout the period under study, chloroform and, to a lesser extent, ether remained the most popular options in the eyes of many Canadian physicians when it came to anaesthetizing birthing women. In the 1861 edition of his popular text *The Principles and Practice of Obstetrics*, Dr. Gunning Bedford noted that he, like many American physicians, favoured ether over chloroform when it came to obstetric cases.<sup>86</sup> Canadian practitioners, however, appear to have, by and large, found chloroform to be

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<sup>83</sup> Mitchinson notes that in 1914-1915, approximately three quarters of patients at the Ottawa Maternity Hospital received some form of anaesthesia, as did more than 80% of patients giving birth at Kingston General Hospital between 1916 and 1920. Mitchinson, *Giving Birth in Canada*, p. 208.

<sup>84</sup> Connor, “To Be Rendered Unconscious of Torture,” pp. 132-133.

<sup>85</sup> Charles Reed, for example, argued that Professors’ lessons about the value of one anaesthetic over others gave “medical students a bent which, once attained, has persisted all their lives.” Reed, *Text-Book of Gynaecology*, p. 88. See also Mitchinson, *The Nature of Their Bodies*, p. 177.

<sup>86</sup> Bedford, *The Principles and Practice of Obstetrics*, p. 711. Mitchinson has suggested that, into the early twentieth century, “ether reigned in the United States,” with chloroform being the choice of many British physicians. Mitchinson, *Giving Birth in Canada*, p. 210.



the preferable anaesthetic. In an 1868 review of Bedford's text, the editors of the *Canada Medical Journal and Monthly Record of Medical and Surgical Science* declared that their own experience was "in favour of chloroform" as opposed to ether.<sup>87</sup> Over the coming decades, international physicians continued to emphasize the safety of the drug, noting that chloroform, when compared with ether, had "the advantage of being more agreeable, more manageable, and more rapid in its action."<sup>88</sup> Canadian practitioners followed suit in highlighting these benefits. Fenwick, for example, noted that chloroform was preferable to ether and advised rural practitioners to always prepare themselves for confinements by including chloroform in their "pocket cases."<sup>89</sup> Adam Wright argued in his 1908 text that "chloroform easily takes precedence over all other anaesthetics," and noted its safety when properly administered.<sup>90</sup> J. McArthur suggested that chloroform was preferable to ether as it could "be more rapidly given" and was "not so complicated to administer."<sup>91</sup> In 1917, Dr. Harry Swartzlander of Oyen, Alberta, stated that chloroform was "the main standby" when it came to obstetric cases.<sup>92</sup> Physician accounts and memoirs demonstrate that chloroform was indeed widely used throughout English Canada.<sup>93</sup> By the interwar

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<sup>87</sup> "Review of *The Principles and Practice of Obstetrics*," *CMJ* 4, no. 10 (April 1868), p. 443.

<sup>88</sup> Lusk, *The Science and Art of Midwifery*, p. 228. See also Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 266; Cooke, *A Nurse's Handbook of Obstetrics*, pp. 158-160; Eden, *A Manual of Midwifery*, p. 726; Berkeley and Bonney, *The Difficulties and Emergencies of Obstetric Practice*, p. 571. Some physicians noted that the effects of chloroform varied depending on the bodily constitution of the woman being anaesthetized. Reed, for example, argued in 1901 that "chloroform acts better upon southern peoples than northerners." Reed, *A Text-Book of Gynecology*, p. 88.

<sup>89</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 63.

<sup>90</sup> Wright noted his growing habit of "combining chloroform and ether" during the second stage of labour. Wright, *A Text-Book of Obstetrics*, pp. 142-145.

<sup>91</sup> McArthur, "Care of the Perineum in Connection with Labour," *DMM* (1907), p. 117.

<sup>92</sup> Harry C. Swartzlander, "The Medical Treatment of Obstetric Cases," *CMAJ* 7, no. 3 (March 1917), p. 223.

<sup>93</sup> For examples, see Bigelow, *Forceps, Fin, and Feather*, pp. 25, 56-57; Withrow, Diary, 8 April 1908, 2 March 1909, Dr. O.C.J. Withrow Papers, AO; Groves, *All in the Day's Work*, p. 12; Johnston, *Before the Age of Miracles*, p. 43.

period, Canadian practitioners including Ross Mitchell confidently proclaimed that “in this section of the continent chloroform is preeminently the anesthetic of labour.”<sup>94</sup>

Canadian physicians routinely argued that ether was often unsuitable for use during confinements, owing to the fact that its more complicated administration posed potential difficulties for the medical practitioner.<sup>95</sup> At the same time, American practitioners, particularly those writing from the northeastern states, argued in favour of its use.<sup>96</sup> Mitchinson suggests that, by the 1920s, Canadian practitioners were also more willing to use ether to anaesthetize their parturient patients.<sup>97</sup> Despite his earlier arguments in favour of chloroform, Adam Wright spoke out on the growing acceptance of ether in Canadian obstetric practice in an address at the 1913 meeting of the Canadian Medical Association: “For many years, it was generally supposed that chloroform was eminently suited for women in labor, and its use was almost universal. In many quarters now, however, ether is considered the better and safer anaesthetic for both mother and babe in forceps and Caesarean operation.”<sup>98</sup> While he did note that chloroform was still “generally preferred” during the majority of confinements, Wright and other practitioners suggested that ether did have a place when physicians increasingly resorted to interventions – including the use of forceps – in the birthing room. As rates of medical intervention continued to rise, it makes sense, then, that the drug was more widely used. Practitioners, including Samuel Peikoff and Clifford Hugh Smylie, recalled the use of

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<sup>94</sup> Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* (1923), p. 719. See also McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 27.

<sup>95</sup> “Medico-Chirurgical Society of Montreal, *Canadian Practitioner* 11, no. 2 (February 1886), p. 55.

<sup>96</sup> Edgar, *The Practice of Obstetrics*, p. 85; Hirst, *A Text-Book of Obstetrics*, pp. 189-190. See also Kerr, *Combined Text-Book of Obstetrics and Gynaecology*, p. 327.

<sup>97</sup> Mitchinson, *Giving Birth in Canada*, p. 209.

<sup>98</sup> Adam Wright, “Anaesthesia and the Forceps in Labor,” *CL* 47, no. 1 (September 1913), p. 7.

ether in obstetric cases during the 1920s.<sup>99</sup> Ultimately, however, Canadian physicians appear to have largely concluded that, though superior to chloroform in cases where surgical anaesthesia was required, ether remained a “less convenient, and less agreeable” option for the average practitioner.<sup>100</sup>

The ways in which practitioners administered inhalation anaesthetics such as chloroform and ether reveal much about wider medical perceptions of childbirth pain throughout the late nineteenth and early twentieth centuries. In her study of the traditional timing of anaesthesia in American obstetrics, Jacqueline Wolf argued that physicians were the ultimate authority when it came to defining the appropriate and/or necessary use of anaesthesia in the birthing room.<sup>101</sup> Throughout this period, the majority of practitioners did not focus their efforts on anaesthetizing women during the transition between the first and second stages – now widely recognized as the most painful part of labour for many women. Rather, they aimed to provide relief during what they saw as the most visibly painful time – the moment of birth itself.

An examination of the ways in which Canadian practitioners were taught to anaesthetize parturient women adds further support to Wolf’s argument. At the turn of the twentieth century, leading Canadian obstetricians including Adam Wright advised their students that if anaesthetics like chloroform were to be offered during the first or second stages of labour, they were to be administered “only to what is called the obstetrical degree.” This qualification meant that, as Wright noted, the patient was “never

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<sup>99</sup> Peikoff, *Yesterday’s Doctor*, p. 4; Smylie, *Personal Memoirs*, p. 187.

<sup>100</sup> Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* (1923), p. 719.

<sup>101</sup> Wolf, “Mighty Glad to Gasp in the Gas,” pp. 365-387.

completely anaesthetized” and never became “totally unconscious.”<sup>102</sup> Students were taught, however, that as the second stage of labour culminated in a moment of “great agony” – the birth of the infant’s head – a higher level of anaesthetic relief was overwhelmingly necessary.<sup>103</sup> At this particular moment, practitioners were advised and agreed on the need to administer chloroform or ether to the “surgical degree,” rendering the parturient patient wholly insensible and unconscious.<sup>104</sup> These views continued into the 1930s, with medical experts only beginning to recognize the “extreme suffering” many women experienced during the transition between the first and second stages of labour in the years following the Second World War.<sup>105</sup> From the male physician’s perspective, as the period during which pregnancy and labour effected the most visible change on the parturient body, women appeared to be in the greatest pain at the moment of birth.<sup>106</sup>

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<sup>102</sup> Wright, *A Text-Book of Obstetrics*, p. 143.

<sup>103</sup> Fenwick, *Manual of Obstetrics, Gynaecology, and Pediatrics*, p. 44. Many of the most popular medical texts of the period, regularly used in Canadian medical schools, singled out the birth of the head as the moment of greatest pain. See Byford, *A Treatise on the Theory and Practice of Obstetrics*, pp. 181-182; Playfair, *A Treatise on the Science and Practice of Midwifery*, p. 237; Edgar, *The Practice of Obstetrics*, p. 434; Jellett, *A Manual of Midwifery for Students and Practitioners*, p. 262; Hirst, *A Text-Book of Obstetrics*, p. 180; Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 275. These ideas suffused medical practice, and were taught to nurses as well. See Cooke, *A Nurse’s Handbook of Obstetrics*, p. 143.

<sup>104</sup> See “Medico-Chirurgical Society of Montreal,” *Canadian Practitioner* 11, no. 2 (February 1886), p. 55; Thomas, *Notes from Lectures on Obstetrics*, p. 27; Wright, *A Text-Book of Obstetrics*, p. 144; Edgar, *The Practice of Obstetrics*, p. 866; DeLee, *The Principles and Practice of Obstetrics*, p. 293; Eden, *A Manual of Midwifery*, p. 327.

<sup>105</sup> See McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 24; Brien, “Sedative Drugs in Obstetrics Practice,” *UTMJ* (1934), p. 49. Though Scott and Van Wyck suggested in 1947 that “toward the end of the first stage, the period of most rapid dilation, [the patient] may give evidence of extreme suffering,” they nonetheless noted that ‘a deeper and more continuous anaesthesia’ was only necessary at the moment of delivery. Scott and Van Wyck, *The Essentials of Obstetrics and Gynaecology*, p. 92.

<sup>106</sup> Elaine Scarry has argued that visible pain has regularly received more attention, of all sorts, than its invisible counterparts. Scarry, *The Body in Pain*, p. 12.

In determining when to provide anaesthesia, medical experts interpreted women's "visual and verbal cues," and as discussed in Chapter 1, relied on their own sensory interpretations of childbirth.<sup>107</sup> By the turn of the twentieth century, Canadian practitioners had done much to silence the voices of their professional rivals, namely midwives. At the same time, many physicians continued to distrust women's own accounts of the bodily sensations they experienced.<sup>108</sup> Additionally, as will be discussed in the following chapter, many well-to-do Canadian women, including expectant mothers, lacked even a basic knowledge of the events taking place during delivery. In this atmosphere, physicians relied on their burgeoning professional reputations and expertise in obstetrics to decree when and how women experienced pain in giving birth. These medicalized interpretations, above all others, gave meaning to the various physiological events and stages of childbirth. As Wolf argues, these views on the proper timing and administration of anaesthesia in the birthing room offer "a classic example of medical authority usurping medical need when defining necessary medical treatment."<sup>109</sup>

Aside from the widespread – if ill-timed – use of inhalation anaesthetics such as chloroform and ether, physicians' pursuit of the "elusive" perfect anaesthetic continued well into the twentieth century. Diverse substances including quinine, chloral hydrate, morphine, and sodium amytal were used during various stages of labour to offer relief.<sup>110</sup> To many Canadian practitioners, well into the interwar years, heroin remained a popular

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<sup>107</sup> Wolf, "Mighty glad to gasp in the gas," p. 377.

<sup>108</sup> Again, see Chapter 1.

<sup>109</sup> Wolf, "Mighty glad to gasp in the gas," p. 383.

<sup>110</sup> Mitchinson, *Giving Birth in Canada*, p. 209. Minutes, Canadian Medical Association Section of Obstetrics and Gynaecology, Canadian Medical Association Fonds, Medical Sections, MG 28 I 343, Volume 6, LAC.

analgesic, often administered during the first stage of labour.<sup>111</sup> Rectal anaesthesia - often given via J.T. Gwathmey's oil-ether colonic method, introduced in the early 1910s – was increasingly used by Canadian practitioners by the 1920s. Many offered praise for the method, noting its particular value for primipara patients, and pointing out that it could “be used as satisfactorily in the home as in the hospital.”<sup>112</sup> This method was also relatively inexpensive, particularly when compared with gas-oxygen or nitrous-oxide analgesia, which also became increasingly popular during the 1920s and 1930s. Canadian physicians seemed to agree on the value of nitrous-oxide, describing the method as “ideal” for use in confinements. Though nitrous-oxide represented, for many practitioners, “the agent of choice in obstetrics,” and earned praise for its rapid effects, the high costs presented an obstacle to its use for many Canadian women, particularly during the Depression.<sup>113</sup> Canadian physicians continued to develop their obstetric anaesthesia and analgesia arsenal in the post-WWII period, relying on a combination of sedative drugs that included Demerol, hyoscine, and seconal, in addition to the older standby, heroin.<sup>114</sup> Jacqueline Wolf has argued that these efforts to uncover the best

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<sup>111</sup> See Wesley Bourne, “Anaesthesia in Obstetrics,” *CMAJ* 14, no. 8 (August 1924), p. 702; Little, “An Address on Obstetrics during the Past Twenty-Five Years,” *CMAJ* (1924), p. 907; Brien, “Sedative Drugs in Obstetric Practice,” *UTMJ* (1934), p. 48; and Harold R. Griffith, “Anaesthesia from the Patient’s Point of View,” *CMAJ* 37, no. 4 (October 1937), p. 363.

<sup>112</sup> John D. Graham, “Rectal Anaesthesia in Obstetrics,” *CMAJ* 15, no. 9 (September 1925), pp. 935-939; R.N. Ritchie, “Rectal Anaesthesia in Obstetrics,” *CMAJ* 16, no. 6 (June 1926), pp. 679-680; For more information, see Wolf, *Deliver Me From Pain*, p. 87.

<sup>113</sup> Gordon G. Copeland, “Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics,” *CMAJ* 7, no. 5 (May 1917), pp. 405-411; Swartzlander, “The Medical Treatment of Obstetric Cases,” *CMAJ* (1917), p. 223; Wesley Bourne and James W. Duncan, “Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics,” *CMAJ* 11, no. 11 (November 1921), p. 822; Mitchell, “Anaesthesia and Analgesia in Labour,” *CMAJ* (1923), p. 718; Bourne, “Anaesthesia in Obstetrics,” *CMAJ* (1924), pp. 702-703; McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 25; Griffith, “Anaesthesia from the Patient’s Point of View,” *CMAJ* (1937), p. 363.

<sup>114</sup> Angus MacMillan, “Anaesthesia for Obstetrics,” *CMAJ* 59, no. 6 (December 1948), pp. 557-559.

options for relieving the pains of parturition were ongoing into the 1960s.<sup>115</sup> At the same time, however, as will be discussed in Chapter 6, the 1940s and 1950s saw the beginnings of a movement away from anaesthetized birth.

In the first decades of the twentieth century, Canadian physicians also ruminated on the value and use of “Twilight Sleep” in obstetrical practice. The term Twilight Sleep was most often used to refer to the narcotic mixture of scopolamine and morphine administered with the dual aim of offering analgesic pain relief and inducing an amnesic or “dammeschlaf” twilight state in the parturient patient.<sup>116</sup> Injections of scopolamine-morphine, or a similar compound of choice, were given at carefully determined intervals, beginning in the early stages of labour. Attending physicians, trained specialists in administering the drug, oversaw the process, monitoring the patient and determining when amnesia had been achieved. Once the medical expert determined that the mother-to-be was fully in a “twilight” state, she was relegated to a quiet room or, ideally, a specially designed “crib-bed” for the purposes of controlling her “sometimes violent movements.”<sup>117</sup> The parturient patient, then, would remain in a haze for the duration of labour, suffering noticeable – but not memorable – discomfort during contractions. Proponents of the method argued that those women who had “Twilight Sleep” births had shortened lying-in periods, and were sooner able to resume their normal activities – an attractive possibility by the 1910s, given growing social and cultural emphases on the

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<sup>115</sup> Wolf, *Deliver Me From Pain*, pp. 73-104.

<sup>116</sup> At times, however, practitioners used “Twilight Sleep” to refer to a broader category of drugs given with the intent to cause amnesia as well as analgesia or pain relief in the parturient patient.

<sup>117</sup> Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986), p. 129.

ideal modern “sturdy, bicycle-riding Gibson girl,” as opposed to the “delicate” and fragile woman of the late-Victorian period.<sup>118</sup>

Invented by the German physician Carl Gauss in 1903, Twilight Sleep drew the attention of North American practitioners by the early 1910s, before it quickly fell out of favour in the following years. While Wendy Mitchinson has suggested that there is little evidence that Canadian doctors widely used “Twilight Sleep” in their obstetric cases, physicians actively discussed the method in their professional journals.<sup>119</sup> One of the earliest Canadian references to the method appeared in the January 1908 edition of the *Canada Lancet*. Dr. F.J. Old, of Port Colborne, Ontario, who had replaced scopolamine with hyoscine when treating his patients, offered a report of “over twenty successful cases” and noted that he found the method particularly valuable in confining primipara mothers with “highly sensitive nervous temperaments.” Old argued that the success of the method depended on meticulous attention to dosage during the early stages of labour, frequent attention to the patient’s memory in order to ensure the preservation of a twilight state, and ongoing efforts to ensure the patient remained quiet before, during, and after the birth. He ultimately concluded that his “few cases” were “not sufficient of themselves to arbitrarily state that this form of anaesthesia is applicable to every case of obstetrics.”<sup>120</sup>

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<sup>118</sup> Jacqueline Wolf argues that “ether and chloroform gained acceptance in an era of glorifying fragile women, but twilight sleep came to public attention when an entirely different view of the idea woman predominated. The sturdy, bicycle-riding Gibson girl was in vogue, and newspapers and magazines promoted twilight sleep according to this new image.” Wolf, *Deliver Me From Pain*, p. 54. Despite the growing acceptance of a new and “sturdier” femininity, physicians continued to highlight women’s highly sensitive and “delicate” nervous temperaments into the interwar period.

<sup>119</sup> Mitchinson, *Giving Birth in Canada*, p. 216.

<sup>120</sup> F.J. Old, “Hypodermic Anaesthesia in Obstetrics,” *CL* 41, no. 5 (January 1908), pp. 348-354.



By the early 1910s, thanks to continuing coverage in the leading medical journals of the day, many Canadian practitioners would have been increasingly aware of the possibilities offered by “Twilight Sleep” techniques.<sup>121</sup> At the same time, prominent Canadian obstetricians, including Adam Wright, commented that they did not routinely use the method in their obstetric practice.<sup>122</sup> In 1915, the editors of the *CMAJ* described Twilight Sleep as “not so much a great discovery as a gradual improvement in a method of drug administration,” associated with “varying and somewhat contradictory results.”<sup>123</sup> Drs. J.G. Gallie and W.A. Scott, Obstetricians at Toronto General Hospital, reported favourable results based on their use of the method in 80 cases over the previous two years, but also noted its limited effectiveness. Twilight Sleep, they found, was most suited to the “private obstetrical case” and those “intelligent” patients – generally held to be the same classes of “delicate” women most likely to experienced undue pain in giving birth, as identified in the previous chapter – who could obey the physician’s orders and rest effectively between the pains: “it is not a method that lends itself to general practice outside the hospital, on account of the time required on the part of the doctor, and the difficulty of obtaining the proper environment.”<sup>124</sup> Over the coming years, research into the method, carried out by obstetricians across the country, yielded similar conclusions.<sup>125</sup> In 1916, Canadian practitioners noted the method had been abandoned at

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<sup>121</sup> See, for example, “Hyoscine-Morphine Anaesthesia in Obstetric Medicine,” *CL* 45, no. 6 (February 1912), pp. 448-449.

<sup>122</sup> Adam Wright, “Anaesthesia and the Forceps in Labour,” *CL* 47, no. 1 (September 1913), p. 8.

<sup>123</sup> “Editorial – Twilight Sleep: The Dammerschlaf of the Germans,” *CMAJ* 5, no. 9 (September 1915), p. 805.

<sup>124</sup> J.G. Gallie and W.A. Scott, “Morphine and Scopolamine Narcosis in Labour,” *CL* 49, no. 2 (October 1915), pp. 65-73.

<sup>125</sup> Obstetricians at Montreal Maternity Hospital found in 1916 that “intelligent” primipara mothers made the “best patients” and concluded that “the treatment is not universal.” Alberta physician Harry Swartzlander found barriers to the use of twilight sleep in country practice.

Johns Hopkins, based on the finding that Twilight Sleep could be safely used only under “exceptional conditions,” and concluded that the effects of the drug – described as an inefficient and dangerous anaesthetic – often rendered it “beyond the control of the physician.”<sup>126</sup> By mid-decade, then, Canadian medical opinions seemed to have been firmly against the widespread use of Twilight Sleep anaesthetics.<sup>127</sup>

Despite the fact that many medical practitioners held largely negative views of scopolamine-morphine anaesthesia, lay audiences clamoured for Twilight Sleep births during these years. American mothers, especially those from the middle and upper social classes, agitated with increasing fervor for their physicians to provide them with Twilight Sleep anaesthesia, and played a major role in sustaining the popularity of the method. North of the border, Canadian practitioners took note of and decried this popularization. A January 1915 piece published in the *Canada Lancet*, for example, criticized recent coverage of “painless childbirth” in the lay press for failing to present “the whole truth” of the picture when it came to Twilight Sleep.<sup>128</sup> Authors noted that this was “one of the serious drawbacks of the popularization of medical topics in magazines”:

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Toronto physician J.A. Kinnear agreed about the suitability of primipara mothers, but argued that a “competent nurse” could remain with the patient, rather than the physician. Nevertheless, Kinnear continued to emphasize the need for the method to be carried out in a quiet, hospitalized setting. J.W. Duncan, Charles Holbrooke, and George Phelan, “Twilight Sleep,” *CMAJ* 6, no. 2 (February 1916), pp. 97-109; Swartzlander, “The Medical Treatment of Obstetric Cases,” *CMAJ* (1917), p. 222; Kinnear, “The Use of Morphine and Hyoscine in Obstetrics,” *DMM* (1916), pp. 57-58.

<sup>126</sup> “Anaesthesia,” *CL* 49, no. 6 (February 1916), p. 267; “Disapproves of Twilight Sleep,” *CL* 50, no. 1 (September 1916), p. 40.

<sup>127</sup> Mitchinson writes that by the mid-1910s, “the consensus of much of the medical press was that [Twilight Sleep] was a fad whose day had gone.” Mitchinson, *Giving Birth in Canada*, p. 218.

<sup>128</sup> Authors singled out Marguerite Tracy and Constance Leupp’s 1914 article in *McLure’s Magazine*. Marguerite Tracy and Constance Leupp, “Painless Childbirth,” *McLure’s Magazine* (June 1914), pp. 37-51. See also Hanna Rion ver Beck, “The Painless Childbirth: Testimony of American Mothers who have tried ‘The Twilight Sleep’,” *Ladies Home Journal* (September

A glowing account of one phase of the subject is usually given and the reader receives a distorted idea of a subject which wise men are still weighing in the balance... there can be nothing but a condemnation of the unreal and one-sided portrayal in a popular magazine of a strictly medical subject such as that of analgesia in obstetrics.<sup>129</sup>

In the coming years, other Canadian practitioners followed suit, expressing concern that the method, in its “immature state,” had drawn the attention of the lay press to the extent that it was “heralded as one of the world’s greatest discoveries – a universal anodyne in child-birth...a magical succor to all womankind in her hour of travail.”<sup>130</sup> By highlighting the drawbacks of this popular coverage, Canadian physicians resisted lay attempts to shape medical-decision making processes.

In opposing the popularization of the method, physicians fundamentally repelled women’s efforts to control the events taking place in the birthing room: as Judith Walzer Leavitt has argued, early twentieth century physicians “did not want to perpetuate the traditional practice of women making these decisions for themselves.”<sup>131</sup> Like their American counterparts, Canadian practitioners vehemently asserted that medical decisions, including those pertaining to the provision of anaesthesia, had to be made by medical experts. In 1915, editors of the *CMAJ* praised Canadian physicians for not yielding to the “indiscriminate demand” for Twilight Sleep.<sup>132</sup> Gallie and Scott argued

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1914), pp. 9-10, and Hanna Rion, *The Truth About Twilight Sleep* (New York: McBride, Nast, and Company, 1915).

<sup>129</sup> “‘Painless Childbirth’ and Painful Magazine Exploitation,” *CL*, 48, no. 5 (January 1915), pp. 291-293.

<sup>130</sup> “Editorial – Twilight Sleep,” *CMAJ* (1915), pp. 807-808.

<sup>131</sup> Judith Walzer Leavitt, “Birthing and Anaesthesia: The Debate over Twilight Sleep,” *Signs* 6, no. 1 (Autumn 1980), p. 160 and Leavitt, *Brought to Bed*, p. 138.

<sup>132</sup> “Editorial – Twilight Sleep,” *CMAJ* (1915), p. 808.

that Twilight Sleep should not be commercialized “by promising it to any particular patient who asks for it.” Instead, they asserted, the practitioner had the power to offer this type of pain relief to patients in what he determined to be “suitable cases.”<sup>133</sup> Here, again, the ultimate decision-making power rested with the medical expert – the physician.

While some practitioners continued to use Twilight Sleep methods into the interwar period,<sup>134</sup> popular agitation for the method had largely subsided by the end of the decade.<sup>135</sup> Looking back on the boom and bust of Twilight Sleep in a 1921 article, Ross Mitchell surmised that, despite some early enthusiasm for the method, growing attention and “extravagant claims” from the lay press prompted the Canadian medical profession’s “decided reaction” against Twilight Sleep. As monthly magazines, “especially those intended for the delectation of American female readers” proffered stories of idyllic Twilight Sleep births, those physicians who opposed the method were, Mitchell argued, made out to be “old fogies.”<sup>136</sup> In such an atmosphere, refusal to provide Twilight Sleep anaesthesia can be interpreted as an effort to maintain or reassert control over the birthing room. By the mid-1920s, physicians including Wesley Bourne, who was affiliated with the Montreal Maternity Hospital, one of the early sites of Canadian research into the method, confidently and resolutely claimed: “we have not employed

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<sup>133</sup> Gallie and Scott, “Morphine and Scopolamine Narcosis in Labour,” *CL* (1915), p. 73.

<sup>134</sup> See U.E. Bateson, “Twilight Sleep in in Obstetrical Practice with Reports of Cases,” *CMAJ* 15, no. 6 (June 1925), pp. 639-640; Berkeley and Bonney, *The Difficulties and Emergencies of Obstetric Practice*, p. 101; Kerr, *Combined Text-Book of Obstetrics and Gynaecology*, pp. 327-328.

<sup>135</sup> Davis, “Painless Childbirth,” *DMM* (1917), p. 82. The 1915 death of one of the most vocal American supporters of the method, Mrs. Francis X. Carmody, was a major blow to the movement. Though Carmody died while giving birth in a New York hospital, her death was allegedly unrelated to the anaesthetic she received. Leavitt, *Brought to Bed*, p. 140.

<sup>136</sup> Ross Mitchell, “The Use of Pituitary Extract and Scopolamine-Morphine in Obstetrics,” *CMAJ* 11, no. 5 (May 1921), p. 351.

‘twilight sleep’ for a long time.”<sup>137</sup> In 1934, Frank Brien of the University of Toronto asserted that “though very popular ten to fifteen years ago,” scopolamine-morphine anaesthetic had largely fallen out of use.<sup>138</sup> Medical emphases on the limited utility of Twilight Sleep continued into the 1940s, with Scott and Van Wyck noting that the method had “fallen into disfavor” in the eyes of many Canadian practitioners.<sup>139</sup>

Despite physicians’ recurring emphases on the many drawbacks of the method, the relatively short-lived popularity of Twilight Sleep anaesthesia did much to reinforce both professional expertise and the ongoing medicalization of childbirth. Throughout the western world, medical professionals routinely and resolutely argued that the complicated method required considerable expertise on the part of the physician. Those who were able to successfully guide their patients through Twilight Sleep births took their place amongst a growing group of specialists in the field of obstetrics. As experts argued that Twilight Sleep anaesthesia should be used “only in a specially equipped delivery room which is protected from all noise and confusion,” the method also presented many well-to-do women, for the first time, with “a compelling reason to give birth in the hospital.”<sup>140</sup> In this sense, the very drawbacks of the method – its complexity, its cost, and the need for minute attention to detail – also mandated increased hospitalization and the growing medicalization of birth. Fundamentally, Twilight Sleep, like other anaesthetics, did much to enhance the scientific aura surrounding obstetrics, the obstetrician, and hospital birth.<sup>141</sup>

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<sup>137</sup> Bourne, “Anaesthesia in Obstetrics,” *CMAJ* (1924), p. 702.

<sup>138</sup> Brien, “Sedative Drugs in Obstetric Practice,” *UTMJ* (1934), p. 47.

<sup>139</sup> Scott and Van Wyck, *The Essentials of Obstetrics and Gynaecology*, p. 104.

<sup>140</sup> Davis, *Painless Childbirth Eutoicia*, p. 43; Wolf, *Deliver Me From Pain*, p. 47.

<sup>141</sup> Wolf, *Deliver Me From Pain*, p. 64.

## Conclusion

The late nineteenth and early twentieth centuries saw significant changes in terms of both physicians' willingness and ability to offer anaesthetic relief to their parturient patients. Though several late-Victorian practitioners argued against the widespread use of obstetric anaesthesia, by the first decades of the new century, the majority of English-Canadian doctors were willing to provide some analgesic or anaesthetic pain relief during childbirth. Practitioners cited a variety of professional, physiological, and humanitarian arguments in favour of anaesthetized birth. These arguments, along with growing emphases on the public health and pronatalist aspects of pain relief, were particularly effective in the years surrounding the First World War, as Canadian physicians argued that relief of the exceedingly painful "birth pangs" experienced by women "in a high state of civilization" was a necessary step towards "the conservation of infant life and adult female health."<sup>142</sup> By the interwar period, many agreed that the risks posed by anaesthetization were "far outweighed by the advantages," and could be "practically annulled" if the expert practitioner exercised "care and judgement" in administering anaesthesia.<sup>143</sup>

The first half of the twentieth century also saw significant development in terms of the professionalization of anaesthesia as a field. While physicians trained in Toronto in the first years of the 1900s may have encountered only a single lecture in the subject, the status of the emerging specialty markedly increased with the establishment of the

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<sup>142</sup> Copeland, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics," *CMAJ* (1917), p. 405.

<sup>143</sup> Mitchell, "Anaesthesia and Analgesia in Childbirth," *CMAJ* (1923), p. 718.

Canadian Society of Anaesthetists in 1920.<sup>144</sup> By the end of the decade, teachers in anaesthesia at both McGill and the U of T had advanced from the rank of demonstrator to lecturer, with an Associate Professor in the field being established at the University of Manitoba. Though calls for greater attention to the subject continued – alongside those for greater attention to obstetrics – anaesthesia had emerged as a distinct professional specialty by the interwar period.<sup>145</sup> Highlighting the scientific nature of the field, some continued to argue that the modern obstetrician ought to secure the services of an additional physician – an expert anaesthetist – to provide pain relief in the birthing room. As these arguments were based on the premise that the satisfactory administration of obstetrical anaesthesia demanded a “a high degree of skill,” the growing prestige of anaesthesia as a medical specialty fundamentally reinforced the professional status of the obstetrician or general practitioner who was able to competently provide pain relief.<sup>146</sup>

In offering anaesthesia to their expectant patients, English-Canadian doctors continued to carve out, define, and justify their role in the birthing room.<sup>147</sup> As the use of anaesthesia increased alongside other obstetrical interventions – including, most notably, rates of episiotomy and forceps use – the provision of pain relief offered physicians

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<sup>144</sup> Samuel Johnston, “An Address on the Growth of the Specialty of Anaesthesia in Canada,” *CMAJ* 16, no. 2 (February 1926), p. 164. Winnipeg anaesthetist W. Webster recalled that during his own student days in the early-twentieth century, the only instruction “consisted of a lecture on chloroform and ether from the professor of materia medica.” W. Webster, “Notes on the Development of Anaesthesia in Western Canada,” *CMAJ* 17, no. 6 (June 1927), p. 727.

<sup>145</sup> Johnston, “An Address on the Growth of the Specialty of Anaesthesia in Canada,” *CMAJ* (1926), p. 165.

<sup>146</sup> Griffith, “Anaesthesia from the Patient’s Point of View,” *CMAJ* (1937), p. 363.

<sup>147</sup> Mitchinson has argued that “doctors did not enjoy seeing patients in pain and the pain of childbirth, coming as it did from a natural function, may have made them question how much they deserved the thanks of women. By being able to offer women a way of avoiding pain, physicians could feel they had done something worthwhile.” Mitchinson, *The Nature of Their Bodies*, p. 179.

additional opportunities to exert professional authority over the bodies of the women they confined.<sup>148</sup> In this sense, as Wolf has argued, pain became *the* key issue emphasized by obstetricians and general practitioners alike to justify their increasing involvement and control when it came to childbirth.<sup>149</sup> Over time, physicians' professional reputation and claims to expertise became increasingly tied to the skilled provision of pain relief. By the mid-1920s, practitioners noted "great demand...for relief from pain" on the part of Canadian mothers, and suggested that "a physician's obstetrical ability [was] judged by a patient and her relatives according to the pain he permits her to suffer."<sup>150</sup> On their part, then, Canadian women played an active role in the medicalization of birth by, at times, vocally demanding anaesthetic relief.<sup>151</sup> As key component of this evolving doctor-patient relationship, medical practitioners relied on a growing body of prescriptive literature to offer carefully curated expert advice on pregnancy, birth, and pain, to lay Canadian audiences.

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<sup>148</sup> It is important to keep in mind, as Mitchinson has argued, that anaesthesia "could relieve the woman of the pain of birth, it could allow for life-saving intervention, and it could also encourage and even cause intervention." Mitchinson, *Giving Birth in Canada*, p. 210.

<sup>149</sup> Wolf, "Mighty glad to gasp in the gas," p. 381.

<sup>150</sup> H.J. Shields, "The Use of Nitrous-Oxide in Labour," *CJMS* 59, no. 3 (March 1926), p. 76.

<sup>151</sup> While American women agitated for Twilight Sleep, Canadian women, on some occasions, vocally called for other anaesthetics. Jayne Elliott, for example, noted that Quebec physician Harold Geggie, who routinely used chloroform in his obstetric practice, recalled "frequent and demanding pleas" – "endormez-moi!" from his French-Canadian patients. Jayne Elliott, "'Endormez-moi!' An Early Twentieth-Century Obstetrical Practice in the Gatineau Valley, Quebec," MA Thesis, Carleton University, 1997, p. 99. For more on how women shaped the ongoing medicalization of pregnancy and birth, see Chapters 5 and 6.



## Chapter 4

### “The Luxurious Daughters of Artificial Life”:

#### Constructing “Delicacy” and Pain in Popular Advice Literature

On an isolated homestead in southern Alberta, Montreal-born Evelyn Cartier Springett recalled her daughter’s birth in 1894: “I shall never forget those awful hours.”<sup>1</sup> Years later, Springett remembered her mother urging her to go to Calgary for the delivery, her sister’s arrival from Montreal to assist as her due date approached, and the arrangements made for the only available physician, Dr. Kennedy, to be on hand for the birth. The baby was expected in late September, but, as Springett wrote in her memoirs, “all of these well-laid plans...were upset by the little one electing to arrive five weeks before she was expected.” Brought up in an urban environment where the help of physicians was increasingly taken for granted, Springett was alarmed to find that as her labour pains intensified, “neither doctor, nurse nor sister was within reach.” Although she could rely on her devoted servant, she surmised, “having a baby under these circumstances is by no means a pleasant experience.” Like many women who went on to record their experiences of birth, Springett’s story was inscribed in memory by the pain and fear that she experienced:

During one long horrible night I suffered in silence, thinking in my ignorance that it was a false alarm, but about five o’clock in the morning I could bear it no longer, and one of the cowboys went galloping off to the station, sixteen miles away, to fetch the station agent’s wife... Though she was vastly better than no one at all, I shall never forget those awful hours before the doctor arrived...When at

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<sup>1</sup> Evelyn Cartier Springett, *For My Children’s Children* (Montreal: The Unity Press, 1937), p. 98.

long last the child was born, I burst into tears at the sight of her; she was so small and frail and weighed not more than five pounds when she was dressed...<sup>2</sup>

Moreover, the baby “cried incessantly for the first few months of her life.” By her recollection, Springett “seemed to have plenty of nourishment for my baby, but she did not thrive; probably because I did not handle her alright. I had been ill off and on for months and was pitifully thin and run-down; and I had no one to advise me, either before or after her advent.”<sup>3</sup> For Springett, the traumatic experience of an isolated, largely unassisted, and unexpectedly early delivery was furthered by her sense of maternal inadequacy, as well as her ongoing “illness,” framed within the dominant medical discourses of the period, which, as described in Chapter 2, increasingly pathologized both pregnancy and birth.

Although each woman’s childbirth experience, in past and present, is unique and individual, Springett’s circumstances are, in some ways, representative of those of many other women in turn of the twentieth century Canada, particularly for those women who lived in rural or isolated areas. In the relative absence of medical professionals, and their inaccessibility to those who could not afford physicians’ fees, there was often no one with the necessary skills, experience, instruments, and drugs to provide reassurance, direction, and relief to expectant patients. Springett, for example, writes regretfully that she had no one, or more accurately, no physician, to advise her for much of her first delivery. While more and more women were able to secure the services of a physician during the actual birth – though the majority continued to deliver in the home, rather than

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<sup>2</sup> Springett, *For My Children’s Children*, pp. 97-8.

<sup>3</sup> Springett, *For My Children’s Children*, p. 98.

in a hospital setting, well into the twentieth century – many were unable, due to a variety of factors, to see a doctor for prenatal visits and guidance.<sup>4</sup>

As late as 1931, obstetricians, including Toronto's renowned Kennedy McIlwraith, lamented that the public, "long in recognizing the dangerous nature of childbirth," was "slow to accept [medical] supervision throughout pregnancy."<sup>5</sup> Though physicians agreed that from "the very outset" of pregnancy the expectant patient "should be instructed as to her personal hygiene, the type of housework which she may carry on, her mode of living, the recreations in which she may indulge, etc." the fact that many women received little in the way of prenatal care remained a significant obstacle in fulfilling this instruction.<sup>6</sup> Prescriptive literature, then, had the potential to fill this crucial gap. Even women such as Springett, living in rural and isolated areas, did often have access to a growing body of medical advice, popular and professional, sometimes in the form of a home remedies book compiled over the generations, or, increasingly, in the form of physician-authored works that they purchased and brought with them in the process of immigration or homesteading.<sup>7</sup> These works had much to say about the value of "modern" medicalized childbirth, the nature of the female body and pregnancy, and the unique and varying levels of pain that women were thought to experience in giving

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<sup>4</sup> The ability to secure a doctor, however, was by no means universal. A July 1923 piece in the *PHJ*, emphasizing the value of maternity care provided by the Victorian Order of Nurses, lamented the experiences of "our women in rural communities never seeing a doctor, or who are seen but once..." Anna L. Prichard, "The Victorian Order of Nurses for Canada: MATERNITY," *PHJ* 14, no. 7 (July 1923), p. 324.

<sup>5</sup> Efforts to improve prenatal care for Canadian women were redoubled in the face of the losses occasioned by the First World War. An emphasis on medical supervision throughout pregnancy was a key part of interwar campaigns to prevent both infant and maternal mortality. McIlwraith, "How to Reduce Maternal Mortality in the Province," *CPHJ* (1931), p. 349.

<sup>6</sup> Joseph N. Nathanson, "Prophylaxis in Obstetrics with Special Reference to the Value and Importance of Pre-Natal Care," *CMAJ* 14, no. 6 (June 1924), p. 496.

<sup>7</sup> Burnett, *Taking Medicine*, p. 50.

birth. As prescriptive and advice books sought, in a sense, to take the lay reader “into the confidence of the medical profession,” the medical expertise of the modern physician was a recurring and ubiquitous theme in virtually all of these discussions.<sup>8</sup>

Focusing on advice literature available to women in Canada and the United States during the late nineteenth and early twentieth centuries, this chapter considers turn-of-the-century medical constructions of “delicate” and “natural” women in the context of childbirth pain as a further means to explore the intersections of gender, class, and race as they shape the representation of female bodies and birth experiences. As with much of the medical textbooks and professional discourse produced during this period, many of these prescriptive works were first published outside of Canada, or written by non-Canadian authors. While the broader geographic context of this discussion, then, is English-speaking North America, I have focused on advice literature commonly available to young English-Canadian women, and have tried to highlight these portrayals wherever possible. Within this body of advice literature, physicians emphasized their professional expertise and differentiated between the pain experiences of rural and urban women as well as between white middle- and upper-class women, working women, and Aboriginal women.

Women’s experiences of childbirth pain have been historical and culturally represented by a variety of different figures, including midwives and nurses,<sup>9</sup> physicians,

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<sup>8</sup> Nathanson, “Prophylaxis in Obstetrics with Special Reference to the Value and Importance of Pre-Natal Care,” *CMAJ* (1924), p. 496.

<sup>9</sup> The diary of Martha Ballard is the most obvious example. See Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Random House, 1991). For a Canadian equivalent, see Charlotte Fuher, *The Mysteries of*

and perhaps most importantly, as will be discussed in the following chapter, women themselves. Though medical experts spoke at length on women's experiences in the birthing room in a variety of professional arenas, the second half of the nineteenth century saw physicians, overwhelmingly male, play a growing role in shaping understandings of how middle-class women experienced pregnancy and birth through popular advice literature. As with much of the medical discourse produced during this period, the representations of women's bodies and birth experiences in prescriptive works were fundamentally influenced by prevailing notions about gender, class, place, and race. Ideas about women's labour pains were premised on the social constructions, emphatically supported by medical science of the time, that construed female bodies (some more than others) as inherently "delicate" and thus potentially unable to withstand pain. Although male physicians could have no sense of the realities of "birth pangs," they capitalized on advancing scientific knowledge, and especially on growing public respect for science, to position themselves as the guardians of both public health and Canada's "prosperity and greatness" and to speak with new levels of authority on the maternal function that defined women's existence in their communications to their female audiences.<sup>10</sup>

An examination of prescriptive works – those volumes of popular medical advice written specifically for a lay audience with the aim of regulating women's conduct in the name of preserving health – offers a window to analyze the dominant and shifting medical perceptions of the delicate female body that were introduced in Chapter 2.

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*Montreal: Memoirs of a Midwife*, ed. W. Peter Ward (Vancouver: University of British Columbia Press, 1984).

<sup>10</sup> Garrett, *Text Book of Medical and Surgical Gynaecology*, p. 12.

Beginning with the pioneering works of Carroll Smith-Rosenberg and Charles Rosenberg in the 1970s, historians have made extensive use of prescriptive materials in discussing medical perceptions of women, but few have analyzed these works with a specific focus on representations of women's pain.<sup>11</sup> For both rural women with limited access to medical care and urban women who sought to embrace "modern" principles of scientific motherhood, advice literature was particularly important, often representing a significant point of contact with mainstream medicine.<sup>12</sup> Although some women did record their experiences of and feelings toward childbirth in diaries, letters, memoirs, and other sources, which will be discussed in the following chapter, the writings of medical professionals were more likely to be published, preserved, and subsequently accessible to historians. These materials also reflect physicians' privileged position in the doctor-patient relationship, and the fact that these medical narratives were often figuratively inscribed on women's bodies reveals much about physician-patient power dynamics in the late nineteenth and early twentieth centuries.<sup>13</sup> While these prescriptive works offer a particular representation of the "delicate woman," her body, and her pain in childbirth, their message was widely disseminated throughout Canada and the United States and was favourably received by the women who were most often the intended audience. Though individual titles suggested that these prescriptive volumes were often directed at "every

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<sup>11</sup> Carroll Smith-Rosenberg and Charles Rosenberg, "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America," *The Journal of American History* 60, n. 2 (September 1973), pp. 332-56.

<sup>12</sup> The relative absence of physicians led Western Canadian women, both Aboriginal and Non-Aboriginal, to encounter one another in an informal system of healing and nursing care. See Burnett, *Taking Medicine*. In this void, advice literature helped to fill a crucial gap.

<sup>13</sup> Kathryn Montgomery Hunter has argued that medical narratives are consistently privileged over patient narratives. Hunter, *Doctors' Stories*.

woman,” many works specified that the advice contained within would be of particular importance to “the young wife.”<sup>14</sup>

As Katherine Arnup has pointed out, one of the major methodological issues involved in a historical reading of advice literature is determining “whether these dicta were ever put into practice, or indeed, whether more than a few patients were ever aware of them.”<sup>15</sup> In this case, high circulation rates and the publication of multiple Canadian editions suggests that advice manuals did make their way to homes and that women, at least those of the middle class, were interested in the information they contained.<sup>16</sup> The fact that some volumes – including *The Canadian Mother’s Book* and *The Little Blue Books* series, both authored by Dr. Helen MacMurchy of the Department of Health, Division of Child Welfare – were widely distributed and had the Canadian government’s official stamp of approval adds weight to the messages these works contained.<sup>17</sup>

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<sup>14</sup> See, for example, Alice B. Stockham, *Tokology: A Book for Every Woman* (Toronto: McClelland and Goodchild Ltd., 1893) and Pye Henry Chavasse, *Advice to a Wife on the Management of Her Own Health, And on the Treatment of Some of the Complaints Incidental to Pregnancy, Labour, and Suckling, with an Introductory Chapter Especially Addressed to a Young Wife* (Toronto: The Hunter Rose Company, 1879).

<sup>15</sup> Arnup, *Education for Motherhood*, p. 7.

<sup>16</sup> George Henry Napheys, *The Physical Life of Woman: Advice to the Maiden, Wife and Mother* (Toronto: Maclear and Company, 1875). The preface to the Canadian edition, for example, asserts that “The Work is highly appreciated where it is best known, a sale of over one hundred thousand copies in a few months amply proves.” Chavasse’s work was published in 1867, 1871 and 1877 before the release of 1879 and 1880 editions. *Tokology* was first published in 1886, before 1893, 1896 and 1911 editions were released.

<sup>17</sup> Helen MacMurchy, *The Canadian Mother’s Book* (Ottawa: Thomas Mulvey, Printer to the King’s Most Excellent Majesty, 1921), Helen MacMurchy, *How to Take Care of the Mother: Little Blue Books Home Series* (Ottawa: F.A. Acland Printer to the King’s Most Excellent Majesty, 1922). *The Canadian Mother’s Book* was in particular high demand, going through six editions by 1933. Looking at the distribution of these works such as these over a one year period in the early 1920s, Arnup estimates that more than one piece of literature was distributed for every six women of childbearing age. Arnup, *Education for Motherhood*, p. 118. In these works, the Canadian government promoted motherhood as a national duty, but held all mothers up to a particular white, upper-middle class ideal, emphasizing the significance of physician care, scientific motherhood, and the medicalization – and later hospitalization – of birth. See also

Published on the heels of the success of the *Little Blue Books* in the years following the conclusion of the First World War, MacMurchy's more extensive *Canadian Mother's Book* (1921) was distributed throughout the country by local and regional health boards, and offered upon request to private individuals, as part of the broader national goal of providing all Canadian mothers, "by every means possible," with the best medical and obstetrical knowledge and care.<sup>18</sup> Its content, however, like much of the prescriptive literature produced during this period, overwhelmingly presented Anglo-Canadian, middle-class standards as the ideal versions of pregnancy and motherhood that all mothers ought to aspire to.<sup>19</sup> Throughout the late nineteenth and early twentieth centuries, medical and public health experts, including MacMurchy, routinely singled out "the mothers of the poor" as "need[ing] to learn a lot of things," or, in other words, requiring the most advice, to successfully bear and raise the next generation of Canadians.<sup>20</sup> As Cynthia Comacchio has suggested, however, a variety of factors, including material conditions, determined how (and the extent to which) women actually followed experts' advice.<sup>21</sup> It is also likely that many working class mothers experienced guilt associated with "the disjuncture between the [middle-classed] requirements of advice" and the reality of their day to day lives.<sup>22</sup> While these sources, then, cannot be

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Diane Dodd, "Advice to Parents: The Blue Books, Helen MacMurchy, MD, and The Federal Department of Health, 1920-1934," *Canadian Bulletin of Medical History* 8 (1991), pp. 203-230.

<sup>18</sup> W.W. Lailey, "The Progress of Maternal Welfare in the United States and Canada," *PHJ* 18, no. 6 (June 1927), pp. 253, 254.

<sup>19</sup> Discussing the ideal home in which to bring up children, MacMurchy, for example, posed the question to her readers: "Are there three bedrooms? One for the father and mother, one for the boys, and one for the girls?" This representation of the ideal home suggested a middle-class, nuclear family environment. MacMurchy, *The Canadian Mother's Book*, p. 23.

<sup>20</sup> "Baby Clinics," *PHJ* 4, no. 2 (February 1913), p. 94. See also McLaren, *Our Own Master Race*, p. 32.

<sup>21</sup> Comacchio, *Nations are Built of Babies*, p. 12.

<sup>22</sup> Arnup, *Education for Motherhood*, p. 145.



regarded as direct evidence of women's actual beliefs or practices, they nonetheless reflect what the authors believed about women's bodies, and what they wanted women readers to believe and practice. This advice literature, and in particular, government-sponsored or endorsed works that were framed as especially imperative in the years following World War I, took on the power of an official discourse. These messages had the potential to influence women's understandings of their own bodies and expectations about childbirth pain, while simultaneously allowing physicians to enhance public credibility for their professional expertise and stake further claim to both women's bodies and the birthing room.<sup>23</sup>

This chapter relies on an examination of a representative sample of published works of prescriptive literature available to Canadian women in the late nineteenth and early twentieth centuries. The majority of these works were authored by physicians, with virtually all of those discussed written by individuals claiming some connection to the medical profession. While male voices predominated in much of the professional medical discourse throughout this period, female authors, writing for expectant audiences, could claim that their gender gave them a heightened knowledge of women's bodies, a point recognized in at least one male-authored volume.<sup>24</sup> Accordingly, I have made a conscious effort to include these works, and incorporate the perspectives of a growing number of women physicians. Fundamentally, though, these doctors both contributed to and echoed the rhetoric of their male counterparts, and all of these works imposed a medical voice on

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<sup>23</sup> Physicians emphasized modern principles of "scientific motherhood" to stake a similar claim to infant care and maternal health. Comacchio, *Nations are Built of Babies*.

<sup>24</sup> Holbrook conceded that "*other things being equal*, a female physician should deal with female patients." Holbrook, *Parturition without Pain*, pp. 69-70. 1871, 1882, and 1896 editions were also published.

the parturient body. This is perhaps unsurprising, given that male physicians were often their instructors and superiors in what remained a male-dominated field. Women physicians, however, did not place the same emphasis on the deleterious effects that education had on the female body, and tended to focus their attentions instead on the restraints posed by middle-class living.<sup>25</sup>

Often re-published in Canada for Canadian readers, many of the works discussed were written by American physicians and first published in the United States. This fact, however, does not detract from the significance of these volumes. As one physician-author, George Henry Napheys, asserted in the preface to a Canadian edition, although “the facts, references, & c. are mainly applied to the United States, where the book was first published, they all tell with equal force” in Canada as well. Napheys cited the sale of “over one hundred thousand copies in a few months” as ample proof that such volumes were equally appreciated by Canadian audiences. One woman, a married mother from New York, saw Napheys’ volume as filling a crucial gap:

There are many things incident to a woman’s physical organization which she needs to know, and concerning which she does still not want to ask a physician, and may not have one at hand when she most desires the information. This book can be easily read and perfectly understood by those not familiar with medical terms...For many years we have often asked for just such a book...<sup>26</sup>

Napheys included 26 additional testimonials from doctors, lay newspapers, and other women as additional evidence that all audiences saw the value of his work.

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<sup>25</sup> See Rosenberg and Rosenberg, “The Female Animal,” p. 343.

<sup>26</sup> Napheys, *The Physical Life of Woman*, preface.

## “Delicate” Women

As discussed, the second half of the nineteenth century saw the consolidation of obstetrics as a new medical specialty that in turn, increased the medicalization of childbirth. The medical construction of certain groups of women as “delicate,” along with the rise of public confidence in scientific medicine, supported the growing pathologization of childbirth. Although medical responses to pain during birth were by no means uniform, by the late-Victorian period, the tendency to view labour pain as religiously justified based on a Christian mandate that giving birth “in sorrow” was “Eve’s curse” had largely declined, replaced by the notion that a humane society, with medical science directing the way, should do everything possible to relieve physical suffering.<sup>27</sup> Changing ideas about pain were also reflected in the growth of antivivisectionist movements in both Britain and North America from the 1870s, spearheaded by middle-class women who saw their own bodies, like those of the animals being vivisected, as similarly controlled by medical men.<sup>28</sup> Although arguments about the moral dangers of anaesthetizing birthing women persisted to limited degree,<sup>29</sup> by the closing decades of the nineteenth century, many physicians accepted the use of chloroform or ether to alleviate women’s pain during childbirth.<sup>30</sup>

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<sup>27</sup> Snow, *Blessed Days of Anaesthesia*, p. 162.

<sup>28</sup> Coral Lansbury, “Gynaecology, Pornography and the Antivivisection Movement,” *Victorian Studies* 28, n. 3 (Spring 1985), pp. 413-37.

<sup>29</sup> Some doctors feared that anaesthesia had the potential to sexually excite labouring women. See Mary Poovey, ““Scenes of an Indelicate Character’: The Medical ‘Treatment’ of Victorian Women,” *Representations*, n. 14 (Spring 1986), pp. 37-68.

<sup>30</sup> Discovered by Scottish physician James Simpson in 1847, chloroform had its first surgical use in Upper Canada in January of 1848 and was used to anaesthetize a labouring woman in July of the same year. English-Canadian physicians generally preferred chloroform to ether. David A.E. Shepard, *Watching Closely Those Who Sleep: A History of the Canadian Anaesthetists Society* (Toronto: University of Toronto Press, 1993), pp. 3, 4. See also Chapter 3.

At the same time, female-dominated cultures of childbirth, whereby a midwife and various female companions assisted during delivery, continued to decline as women, particularly in urban areas, gave birth less frequently and increasingly turned to physicians and scientific medicine for assistance. The presence of physicians, usually men, fundamentally changed gender and power dynamics in the birthing room. A belief that hospitals were dangerous places fit only for the destitute persisted into the early decades of the twentieth century, however, and the majority of births still took place in the home.<sup>31</sup> While midwives continued to assist the majority of working and rural women during childbirth,<sup>32</sup> and women were by no means passive participants in the process of medicalization,<sup>33</sup> physicians increasingly sought to create a demand for their services amongst those patients who could afford them, particularly middle- and upper-class women in urban areas. One strategy for carving out this professional niche was to emphasize the heightened pain that these women supposedly experienced in giving birth in advice books, pamphlets, and articles that were explicitly intended for lay public consumption. By the first decades of the twentieth century, the physician-authors of prescriptive works routinely asserted, for example, that it was “an established fact that no small number of women endure exquisite pain during the process of childbirth, are nervous wrecks for weeks following the birth of the baby, and practice future sterility

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<sup>31</sup> The hospital only became the preferred destination of “respectable” middle-class patients, who had previously opted to receive a physician’s care at home, during the interwar period. Gagan and Gagan, *For Patients of Moderate Means*, p. 4. The shift from home to hospital for birthing women, however, was less drastic and less uniform.

<sup>32</sup> Mitchinson, *Giving Birth in Canada*, p. 102.

<sup>33</sup> Women always retained some agency in these encounters, choosing when and how to seek out a physician and, as was the case with campaigns for Twilight Sleep in the 1910s, being the ones to actively demand anaesthesia. See Leavitt, “Birthing and Anaesthesia: The Debate over Twilight Sleep,” pp. 147-64, and Mitchinson, “Agency, Diversity, and Constraints,” pp. 122-49.

because they fear and dread the anguish of another confinement.”<sup>34</sup> As demonstrated in much of the professional medical discourse produced during this period, white middle- and upper-class women were thought to be increasingly sensitive due to their biology and the unique constitution of the female body. Thus, prescriptive works emphasized the ways in which gender alone made women more sensitive and vulnerable to all varieties of pain than men.

Mainstream medical discourses held that women were especially susceptible to a variety of corporeal complaints and increasingly sensitive to pain due in large part to the inherently weak – or, in the eyes of many social commentators, appropriately feminine and delicate – nature of the female body. Medicalized representations of the female body, communicated to popular audiences, placed a heavy emphasis on the centrality of a woman’s reproductive organs, consistently affirming the significance of a “heart-like” uterus that governed the female body and “mandate[d] the medical profession’s superintendence of women.”<sup>35</sup> In his 1875 volume, *Parturition without Pain: A Code of Directions For Escaping From the Primal Curse*, American physician and health reformer M.L. Holbrook recounted a widely-held analogy amongst physicians – that it was “as if the Almighty in creating the female sex, had taken the uterus and built up a woman around it.”<sup>36</sup> Other physicians agreed, and advised women that “the number of

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<sup>34</sup> A. Smith, *Twilight Sleep in America: The Truth about Painless Childbirth* (New York: The Victor Publishing Company, 1915), p. 10.

<sup>35</sup> Poovey, “Scenes of an Indelicate Character,” pp. 145-6.

<sup>36</sup> Holbrook, *Parturition without Pain*, p. 12.

diseases to which the uterus as a whole is subject is so large that there is scarcely any other organ in the body which is so likely to be attacked.”<sup>37</sup>

Physician-authors also increasingly identified a category of ailments that exclusively affected the female body. Boston-based Dr. Ira Warren, for example, wrote in the 1884 edition of *Warren’s Household Physician* that “women are subject to a class of distressing complaints peculiar to themselves...involving considerations of a delicate nature.”<sup>38</sup> Women physicians, including Minnesota’s Dr. Mary Melendy, whose work was published in both the northern United States and Canada, echoed this viewpoint, highlighting the many ways in which the delicate female constitution set women up for virtually a lifetime of troubled health.<sup>39</sup> As pregnancy and childbirth represented the primary purpose of a woman’s (reproductive) existence, prescriptive volumes overwhelmingly focused on women’s experiences during these crucial periods. Alongside the increasing pathologization of these processes in professional medical literature, the messages women received reflected the growing view that these periods of a woman’s life were times when so-called “female troubles” could reach new heights; by the second half of the nineteenth century, the growing consensus was that “childbirth, even if not interfered with, could result in the ill health of women.”<sup>40</sup> Prescriptive volumes routinely

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<sup>37</sup> *Every Woman Her Own Doctor: A Complete Book in Plain English Concerning Ailments and Accidents to which Women and Children are Liable and their Cure, By a Fully Qualified MD* (London: C. Arthur Pearson, Ltd., 1903), p. 221.

<sup>38</sup> Ira Warren, *Warren’s Household Physician* (Boston: Ira Bradley and Company, 1884), p. 339.

<sup>39</sup> Mary R. Melendy, *Ladies Home Companion: A Book Giving Full Information on all the Mysterious and Complex Matters Pertaining to Women* (Brantford: The Bradley Garretson Company, 1903), p. 17.

<sup>40</sup> Mitchinson, *The Nature of Their Bodies*, p. 223.

emphasized that a key component of this general “ill health” was the unprecedented levels of pain that certain groups of women were thought to experience in giving birth.

Medical and popular ideas about some women’s unique susceptibility to pain markedly intensified during the Victorian era in response to broader sociocultural transformations taking place in Canada and the United States. Despite the fact that, at the end of the nineteenth century, women were living longer lives than ever before, Martin Pernick has suggested that traditional beliefs, including the idea that women’s bodies were weaker and more fragile than men’s, “gained added significance as a result of the Victorian penchant for polarizing and dichotomizing sex roles in society.”<sup>41</sup> This conservative desire to maintain a polarized gender system certainly extended to English-Canadian society as well, and promoting expert ideas about female sensitivity, particularly to popular audiences, had the potential to shore up traditional gender roles, a process that was seen by many social commentators as all the more necessary given the emergence of the “New Woman” in the closing decades of the nineteenth century. While a white, middle-class woman’s delicate nature rendered her vulnerable to pain, by the same logic, she was also thought to be too delicate to adequately cope with pursuing a higher education, riding a bicycle, or participating in other aspects of modern public life.<sup>42</sup> In this way, the heavy emphasis on the sensitivity of these particular groups of women, and accordingly, on traditional gender roles, also marked growing tensions surrounding modernity – namely the weakening of the traditional status quo.

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<sup>41</sup> Pernick, *A Calculus of Suffering*, p. 149. At the same time, maternal mortality remained an ongoing source of anxiety and concern.

<sup>42</sup> See Mitchinson, *The Nature of Their Bodies*, pp. 48-76 and Margaret A. Lowe, *Looking Good: College Women and Body Image, 1875-1930* (Baltimore: Johns Hopkins University Press, 2003), pp. 29-53.

Cultural historians have positioned the North American city as “one of the crucial sites of modernity – the point of its intensification.”<sup>43</sup> Given the fact that, as Nicholas Kenny has recently argued, the modern city was fundamentally “a place of heightened bodily sensation,” it makes sense that the bodies of urban-dwelling women would be perceived differently than those of their rural counterparts.<sup>44</sup> By century’s end, as historian Keith Walden puts it, “even those most insulated from overt effects and most determined to resist intrusions could sense that Western society was shifting its axis...the world seemed to have speeded up, to have become more complex.”<sup>45</sup> And as the world “sped up” for many Canadians, the new pace of city life was seen to have unintended and adverse consequences on women’s bodies.

As unprecedented numbers of Canadians moved from rural to urban environments during the second half of the nineteenth century, the authors of advice literature increasingly advanced the opinion that city life had ill effects on the bodies of women. These damaging effects, they claimed, increased women’s sensitivity. Late nineteenth and early twentieth century medical discourse certainly demonstrated, as Mitchinson has argued, physicians’ widely held belief that “the problem” of weak and fragile female bodies “was increasing as the pressures and challenges of modern society took their toll....and this was of special concern with respect to young women entering puberty.”<sup>46</sup>

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<sup>43</sup> Simon Gunn, *History and Cultural Theory* (London: Pearson Longman, 2006), p. 124.

<sup>44</sup> In his examination of urban transformations in Montreal and Brussels, Kenny suggests that “the body played a fundamental role in mediating the relationship between city dwellers and urban environments, propelling the tangible physicality of streets and buildings into the realm of individual consciousness and public discourse.” Nicholas Kenny, *The Feel of the City: Experiences of Urban Transformation* (Toronto: University of Toronto Press, 2014), pp. 3, 4.

<sup>45</sup> Keith Walden, *Becoming Modern in Toronto: The Industrial Exhibition and the Shaping of a Late Victorian Culture* (Toronto: University of Toronto Press, 1997), p. 4.

<sup>46</sup> Mitchinson, *The Nature of Their Bodies*, p. 278.



Organizations including the Canadian Council of Women and the Victorian Order of Nurses expressed the official opinion, in the closing years of the century, that the “delicate bodies of young girls have been allowed to simply grow up in a manner which is a disgrace to this advanced civilized age.” As a result, the health of Canadian girls, while not as poor as that of their American counterparts, could not be compared with the more favourable condition of European women, and was “far from what [reformers] could desire.”<sup>47</sup> While the authors of advice literature asserted that the “unnaturalness” of city life prompted early menstruation – a condition Warren described to female audiences as “not desirable” but “hastened by high living, by the whirl, and bustle and excitement of city life”<sup>48</sup> – the pressures of urban life were also thought to further remove the female body from its “natural” state, rendering childbirth an “unnatural” and increasingly pain-ridden process. In his 1875 volume, Holbrook highlighted the influence of the city in rendering childbirth increasingly painful. Holbrook advised women that improper methods and habits of living made urban women more delicate than ever; those who adopted indolent habits and behaved as “luxurious daughters of artificial life,” he asserted, had much to fear about the “natural” process of giving birth.<sup>49</sup>

The unhealthy means of living noted by Holbrook and other physicians were inherently connected with the “unwholesome atmosphere” of city life in much of the advice literature produced during these decades.<sup>50</sup> In 1893, Chicago-based obstetrician

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<sup>47</sup> The Canadian Council of Women and Victorian Order of Nurses, *Woman: Maiden, Wife, and Mother – A Study of Woman’s Worth and Work in All Departments of Her Manifold Life, Education, Business, Society, Housekeeping, Health, Physical Culture, Marriage, and Kindred Matters* (Toronto: The Linscott Publishing Company, 1898), pp. 373, 212.

<sup>48</sup> Warren, *Warren’s Household Physician*, p. 341.

<sup>49</sup> Holbrook, *Parturition without Pain*, p. 17.

<sup>50</sup> Here, physicians echoed earlier miasmatic theories. Holbrook, *Parturition without Pain*, p. 31.

and gynaecologist Dr. Alice Stockham, one of the few female specialists in this exclusively female-focused specialty, advised her expectant readers that excessive pain in childbirth was “a morbid symptom...a perversion of nature caused by modes of living not consistent with the most healthy condition of the system.”<sup>51</sup> As Stockham’s statement demonstrates, physicians’ relationship with “nature” was, during this period, often characterized by ambiguity. Appeals to nature provided justification for women’s gender roles, but nature was also something to be conquered through medical science. In pointing out the “morbid” quality of these heightened pains, then, Stockham suggested to her lay readers that the only way to restore women’s “natural” role and function was by turning to the physician and medicalized birth.<sup>52</sup>

By the first decades of the twentieth century, these growing tensions surrounding modernity and the perceived pressures of modern life prompted a growing number of medical experts to speak out, on a broader level, regarding the dangers associated with the movement away from “natural” lifestyles and habits as they related to childbirth. These messages appeared to increase after 1918, as the bodies of women gained new meaning in the post-WWI years in light of what some saw as women’s biological duty to replace the fallen. In a 1920 piece published in *Woman’s Century*, the official magazine of the Canadian National Council of Women, Dr. Abraham Groves argued that “every artificial change or departure” from nature, including seemingly unrelated habits like the wearing of high-heeled shoes, had negative effects. Pain and suffering of all types, including “the increased agonies that women suffer during child-birth,” were the potential

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<sup>51</sup> Stockham, *Tokology*, p. 18.

<sup>52</sup> For more on this ambiguous relationship see Mitchinson, *The Nature of Their Bodies*, pp. 30-31.

results.<sup>53</sup> As the medicalization of pregnancy and birth continued, delicate and weakened city-dwelling women were, more and more, cast as the ideal candidates for anaesthetic relief.<sup>54</sup> It is important, however, to consider that anaesthesia was more available and readily used in urban areas, and was almost always reserved for those women who sought out and could afford to pay for its use.<sup>55</sup> The complex relationship between anaesthetization, place, gender, and class may help explain why urban women were perceived and portrayed as experiencing more pain – there were more opportunities to diagnose and treat it.

As in much of the professional medical literature produced during this period, advice volumes commonly contrasted the painful childbirths peculiar to urban-dwelling women with the less painful births of their rural counterparts. Springett's story, which opens this paper, while emphasizing the difficulties of her largely unassisted birthing experience, might have been seen to support these assertions. Although her marriage took her to a southern Alberta ranch, she was-born and raised in an affluent Montreal family, which, according to the medical rhetoric of the time, likely damaged her health, rendering her more susceptible to a variety of health complaints including sterility.<sup>56</sup> These

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<sup>53</sup> Abraham Groves, "The Hospital Age," *Woman's Century* (July 1920), reprinted in Groves, *All in the Day's Work*, p. 169.

<sup>54</sup> Buffalo physician John H. Dye asserted in his 1912 volume, for example, that he would "not hesitate for a moment" in administering anaesthetic to "a weak and feeble woman, suffering intensely." He continued: "it is a popular supposition that in feeble, anemic, nervous, and delicate persons the anaesthesia is specially dangerous, but this is a great mistake; *as a rule, such persons bear it best.*" John H. Dye, *Painless Childbirth, or Healthy Mothers and Healthy Children: A Book for All Women*, Seventeenth Edition (Buffalo: Dr. J.H. Dye Medical Institute, 1912), p. 160.

<sup>55</sup> Use of an anaesthetic could raise a physician's fee by 30-50 percent. Snow, *Operations without Pain*, p. 120.

<sup>56</sup> Springett writes that her father "must have some misgivings at the thought of what life on a ranche might be to a girl brought up as I had been, one of a large family, accustomed to a comfortable home." Springett, *For My Children's Children*, p. 69. One physician, writing in the

anxieties went hand in hand with the ongoing processes of industrialization and urbanization, and are evident in much of the prescriptive literature produced during these transformative years.

Ideas about the moral and physical dangers of the city were part of a growing atmosphere of anti-modernism and a desire to return to a more “authentic” type of rural living.<sup>57</sup> These tensions were particularly resonant in turn of the twentieth century Canada, as the nation struggled with conflicting rural and urban identities in the post-Confederation years. As Canada struggled to define itself and its citizenry, both in terms of respectable feminine behaviour and the ideal female body, class-based tensions (exacerbated by industrialization, urbanization, and immigration) also came into play in a major way. While the artificiality of the city rendered the bodies of women who lived in urban settings increasingly delicate, the unnaturalness of modern urban life, and the habits that attended it, were thought to be significantly and dangerously compounded by class.

In advice literature directed at young wives and expectant mothers, nineteenth century physicians suggested that women from the middle and upper classes were increasingly delicate and sensitive for two main reasons. First, when compared to men, but also when compared with women from rural or working-class backgrounds, they were less likely to be healthy in a physical sense, having led sheltered and opulent lives

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early 1900s, suggested that though up to 10% of women were sterile, this percentage reached as high as 16 or 17% “in the upper social ranks.” *Every Woman Her Own Doctor*, pp. 21-22.

<sup>57</sup> For more on the perceived dangers of urban life as they pertained to girls, in particular, see Carolyn Strange, *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930* (Toronto: University of Toronto Press, 1995).

due to their superior social standing. One physician-author suggested that while many women brought up in this manner were “fit candidates for matrimony, well-qualified in every respect to share the homes and cheer the firesides of good and worthy men,” few were “fit physically to risk becoming mothers.”<sup>58</sup> In the late nineteenth century, this idea was commonplace, and as historian Ann Dally has suggested, the prevailing construction of the female body held that middle-class women were “delicate and ailing...the middle-class female in a decline was the epitome of the nineteenth century woman.”<sup>59</sup> These well-to-do women, already weakened by their upbringing and lifestyle, did little to improve their physical condition, and, in effect, their pain tolerance. Bending has suggested that, in fact, many were seen to be doing the opposite, and that the typical “supersensitive civilized woman” tended to avoid discomfort and “live an ‘unnatural’ and luxurious life, thus allowing, and indeed, precipitating the enervation of [her] faculties.”<sup>60</sup> As “civilized” women continued to lead sheltered lives and did their best to avoid any painful or strenuous experiences, medical experts argued that this had the unintended effect of increasing sensitivity, including during childbirth. Holbrook, for example, suggested that “the previous life of the mother” was the determining factor in “what her danger, her difficulty, and her pain during childbirth shall be,” and concluded that “her easy or difficult labor, in fact, is almost entirely her own work.”<sup>61</sup> Writing decades later, Melendy agreed, and framed her own volume as aiming “to instruct women in what

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<sup>58</sup> H. Arthur Allbutt, *The Wife's Handbook: How a Woman Should Order Herself during Pregnancy, in the Lying-In Room, and After Delivery* (London: W. J. Ramsey, 1886), preface.

<sup>59</sup> Ann Dally, *Women Under the Knife: A History of Surgery* (New York: Routledge, 1991), pp. 23, 86.

<sup>60</sup> Bending, *The Representation of Bodily Pain*, p. 124.

<sup>61</sup> Holbrook, *Parturition without Pain*, p. 20.

manner they are directly or remotely responsible for much of their own sufferings...and how this may be avoided.”<sup>62</sup>

An examination of predominant medical advice from the late-Victorian years suggests that these beliefs about the relationship between class, health, and sensitivity were widely held and readily communicated to Canadian audiences. Pye Henry Chavasse’s popular 1879 volume, *Advice to a Wife on the Management of Her Own Health* – a work recommended, decades later, by leading American obstetrician Joseph DeLee as one of the best available books on the care of the mother during pregnancy<sup>63</sup> – provides a striking example of some of this rhetoric. In his description of the circumstances surrounding stillbirths, Chavasse, a member of Britain’s Royal College of Surgeons, remarks:

It is not the poor man’s wife, who toils for her daily food, who ‘rises up early, and so late takes rest, and the bread of carefulness’ that most frequently has still-born infants – certainly not: but it is the rich man’s wife, who lolls in easy chairs and luxurious carriages, who fares sumptuously every day, and who nestles in beds of down, that is more likely to have them, as the *Births* in the fashionable newspapers abundantly yet laconically testify.<sup>64</sup>

Here, the wives of the rich were charged with living “luxurious” and “sumptuous” lives, fundamentally weakening their bodies, and rendering them more likely to give birth to stillborn infants –an outcome which, like increased levels of pain during childbirth, was seen to arise from the unhealthy condition of the mother. While Chavasse singled out

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<sup>62</sup> Melendy, *Ladies’ Home Companion*, p. 18.

<sup>63</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 228.

<sup>64</sup> Chavasse, *Advice to a Wife on the Management of Her Own Health*, p. 231.

women hailing from the upper classes, late nineteenth and early twentieth century physicians increasingly expressed concern over the health of all “modern” Canadian women, including those of more modest – yet still “fashionable” or “respectable” – middle-class backgrounds. Such women, who as Chavasse infers here were generally assumed to reside in urban areas, were seen to lead lives that were less natural than those of poorer women, who were associated with a rural lifestyle and more likely to be charged with the performance of physically taxing tasks on a regular basis. This rhetoric suggested to expectant audiences that, in effect, these privileged women would also be more sensitive to the pain of giving birth, particularly when compared to working-class women, who, as historians have demonstrated, and as both professional and prescriptive medical literature from the period also indicates, were commonly assumed to be “at a lower stage of evolutionary development.”<sup>65</sup>

Another part of the explanation for middle and upper-class feminine delicacy was thought to lie in the continuing pressure of being “cultured.” Needing to maintain a respectable and refined image, women from these favoured social strata were thought to face increased nervous pressures on a daily basis. As discussed in Chapter 2, late-Victorian physicians claimed that women experienced intellectual strain from their growing desire to be educated. Many doctors “lent their expertise to the notion that all women had more delicate nerves and therefore greater sensibility than men.” Late nineteenth century specialists in neurology, however, also increasingly articulated the belief that having a delicate nervous system – or, in other words, the highly developed or complex nervous organization that was a characteristic of one’s superior position in the

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<sup>65</sup> Dally, *Women Under the Knife*, p. 86.

evolutionary hierarchy – also “betokened both social and moral status.”<sup>66</sup> The white, well-to-do women who were most often recognized as possessing such delicate nerves were also seen as the most likely to suffer from neurasthenia.<sup>67</sup> Contemporary medical advice literature linked the increasing fragility of these women with perceived emotional instability. Stockham announced to her lay readers that physicians regularly found “in women of superior education and marked intelligence an exaggerated development of the emotional nature, and a corresponding deterioration of the physical powers” and suggested that most women in these categories were regularly condemned to lives of “weakness, debility and suffering.”<sup>68</sup> Accordingly, and since all women were already depicted as and perceived to be less resistant to bodily ailments and pain, many physicians and social commentators argued that education for girls – an indicator of social rank and the family’s ability to educate children instead of requiring their labour in the home – had to be “especially circumscribed and carefully counteracted by physical exercise.”<sup>69</sup>

This type of moderate and appropriate physical exercise, experts argued, ought to continue throughout a woman’s life, with special attention paid to the period of gestation. By the closing decades of the nineteenth century, as part of what was perhaps both a conscious effort to counteract and a continuation of established emphases on a genteel and fashionable image for Victorian women, physicians advised their lay readers that the type and amount of exercise to be undertaken during this crucial period of pregnancy was

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<sup>66</sup> Bending, *The Representation of Bodily Pain*, p. 181.

<sup>67</sup> See Napheys, *The Physical Life of Woman*, p. 42.

<sup>68</sup> Stockham, *Tokology*, p. 19.

<sup>69</sup> Pernick, *A Calculus of Suffering*, p. 152.



limited by both “the dictates of common sense and the woman’s own sensations;” physicians reminded expectant mothers that “the nervous and delicate cannot make with safety their customary daily exertions in the performance of their household or social duties and pleasures.”<sup>70</sup> Activities such as running (especially up or down stairs), dancing, the lifting of heavy weights, riding in carriages, and travelling by railway were seen as contributing to “shocks, fatigue, or over-exertion,” and as such, were singled out as problematic.<sup>71</sup> Moderate outdoor exercise, on the other hand – most often in the form of walking, gardening, or housework – was regularly recommended. This type of physical training, framed as having the ability to “make the delicate woman strong,” was seen by many experts as “essential to a healthy accouchement.”<sup>72</sup>

Alongside medical rhetoric emphasizing the dangers of higher education for girls, physicians also recognized that young women hailing from the upper and middle classes, particularly during the late-Victorian period, faced unique pressures to maintain an appropriately refined and fashionable image – one that would suit them for marriage. Alice Stockham addressed this issue in her own volume, citing the respected American gynaecologist Dr. Theodore Gaillard Thomas’ work to advise her readers that young women in the late nineteenth century were “too willing to be delicate, fragile and

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<sup>70</sup> Napheys, *The Physical Life of Woman*, p. 176.

<sup>71</sup> Napheys, *The Physical Life of Woman*, p. 176, The Canadian Council of Women and Victorian Order of Nurses, *Woman: Maiden, Wife, and Mother*, p. 240, Prudence B. Saur, *Maternity: A Book for Every Wife and Mother* (Chicago and Philadelphia: L.P. Miller and Company, 1887), pp. 210-211.

<sup>72</sup> Saur, *Maternity: A Book For Every Wife and Mother*, pp. 210-211, Marion Harland, *Eve’s Daughters: or, Common Sense for Maid, Wife, and Mother* (Toronto: Rose Publishing Company, 1892), pp. 320-321. See also *Girlhood and Wifehood: Practical Counsel and Advice, By a Surgeon & Accoucheur, Member of the Royal College of Surgeons, London* (London: The “Family Doctor” Publishing Company, 1896), pp. 133, 176-177.

incapable of endurance. They dread above all things the glow and hue and health, the rotundity and beauty of muscularity...these attributes are viewed as coarse and unladylike.” These women, Thomas and Stockham went on to assert, regularly, “furnish[ed] employment for the gynaecologist.”<sup>73</sup> In their efforts to raise “fashionable” and respectable future wives, middle-class mothers were especially seen to be setting their daughters up for a lifetime of ignorance and pain. By the turn of the twentieth century, Canadian practitioners including Jennie Drennan readily recognized that discussions of “delicate subjects” including reproductive matters were “often neglected” amongst Canadian families, and argued that “ignorance is no excuse for the laity, nor is false modesty any excuse” for the medical practitioner in allowing this neglect to continue.<sup>74</sup>

Recognizing their captive audience of future mothers, many of whom would go on to raise daughters of their own, the authors of advice literature also increasingly spoke up on the dangers of maternal ignorance. Elisabeth Robinson Scovil, who aside from her work as a hospital superintendent had served as associate editor of the *Ladies Home Journal*, noted in her 1896 volume, *Preparation for Motherhood*, that the ambition to raise respectable young women prompted many mothers to avoid discussing sex and reproduction with their daughters and cited this aversion as an overwhelming reason why many women were unhealthy.<sup>75</sup> In the pursuit of modesty, these daughters were denied valuable knowledge about their own bodies (and, as Scovil put it, “the laws of health”),

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<sup>73</sup> Stockham, *Tokology*, p. 19.

<sup>74</sup> Drennan, “The Physiological Generative Cycle of Woman,” *DMM* (1903), p. 188.

<sup>75</sup> Elisabeth Robinson Scovil, *Preparation for Motherhood* (Philadelphia: Henry Altemus, 1896), p. 265.

and continued to subscribe to the decadent lifestyles they were born into. Physician-authors, including Dr. Emma Angell Drake, a graduate of Boston University Medical College, offered their readers cautionary tales of the “multitude of young wives who come to motherhood wholly untaught,” and argued that such women overwhelmingly “lament[ed] their ignorance” when faced with the harrowing realities of pregnancy and birth.<sup>76</sup>

Despite these efforts and warnings, Canadian practitioners continued to widely bemoan the utter lack of awareness of many of their obstetric patients. In 1919, New Brunswick Minister of Health Dr. W.H. Roberts, declared,

as a physician of some twenty-five years’ standing, and I am sure my experience is in consonance with that of my colleagues, that in presenting a mother with her first baby, and almost without reference to her social station, one might almost as well present her with a copy of Homer in the original and expect her to make rational use of it.<sup>77</sup>

Other practitioners placed the blame for such ignorance squarely in the hands of expectant mothers, and commented that because “most women have sufficient to do in their household,” the question of prenatal education and requests for recommendations in terms of prescriptive works rarely came up.<sup>78</sup>

As part of a broader transformation in public health throughout the first half of the twentieth century, however, physicians increasingly took it upon themselves and called

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<sup>76</sup> Emma F. Angell Drake, *Maternity Without Suffering* (Toronto: William Briggs, 1902), p. 9.

<sup>77</sup> Roberts, “The Reconstruction of the Adolescent Period of Our Canadian Girl,” *PHJ* (1919), p. 495.

<sup>78</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 228.

upon their peers to take a more active role in educating the next generation of Canadian mothers. These efforts reached new heights during the interwar period, as public health experts were galvanized by the losses of the First World War. In 1932, C.A. Baragar, the Alberta Commissioner of Mental Health, called on medical experts to fully introduce Canadian girls to “the facts of maturity and of their responsibilities and privileges in motherhood” by the time they reached the late teens, and argued that young women should “be taught to look forward to it [motherhood] as a physiological process comparable with the best of health, an experience associated with joy, happiness, and opportunity, but never with fear of invalidism.”<sup>79</sup> Many physicians may have recognized the difficulties involved with this type of instruction, particularly given the ongoing pathologization of childbirth in professional medical discourses throughout these decades. Some experts suggested that this type of “mother-appropriate” education required offering patients a carefully selected and limited amount of information on what they could expect during delivery. DeLee, for example, questioned “the wisdom of giving gravidae books which describe the anatomy and physiology of the function [childbirth],” and advised practitioners to recommend that their parturient patients avoid such works.<sup>80</sup> Many works, accordingly, assumed a light and conversational tone, with physicians advising their female readers that pregnancy and childbirth “is not some strange thing which is going to happen to you. It is the right, natural and healthy thing for you, just as it was for your own mother when you were born.”<sup>81</sup> The messages about the physiological nature of pregnancy and parturition, that were offered, however, meant to foster

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<sup>79</sup> C.A. Baragar, “The Mental Hygiene of the Critical Epochs of Life,” *CPHJ* 23, no. 3 (March 1932), p. 131.

<sup>80</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 228.

<sup>81</sup> McMurchy, *The Canadian Mother's Book*, p. 7.

pronatalism and provide Canadian mothers with the “right mental outlook” during the prenatal period, were often contradicted by recurring depictions of the pain and suffering involved in childbirth.<sup>82</sup>

### Constructing “Natural” Bodies and Births

Different categories, centred on notions of place and race, meant that women so-classified were thought to experience different levels of pain in giving birth. Popular and professional medical discourses alike held that those women residing in urban areas contended with the daily pressures of living in cities, often at the cost of fostering delicate nervous systems, as well as the increased pain and irritability that accompanied such problems. Within cities, women hailing from the well-to-do classes were routinely thought to be less physically healthy and to face greater intellectual pressures than their working class counterparts – characteristics seen as contributing to their heightened sensitivity. Although the physician-authors of advice volumes discussed did not always explicitly use the term “white”, women who could be seen as such and particularly those having claim to a high degree of “whiteness” were thought to feel increased pain; their deliveries were consistently contrasted with the more natural and less painful labours of women who represented racial others.<sup>83</sup> These ideas about who felt pain, and to what

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<sup>82</sup> Baragar, “The Mental Hygiene of the Critical Epochs of Life,” *CPHJ* (1932), p. 123.

<sup>83</sup> Rather than using the term “white,” authors compared the bodies and birth experiences of “Indians,” “squaws,” or “those women of savage nations,” to those of “their more civilized sisters,” “women in civilized nations,” “our women,” or women of “this country” (in reference to the United States). Accordingly, as with much of the professional literature published during this period, emphasis on “whiteness” was often implied, rather than explicitly articulated.

extent, arose out of rapid socioeconomic change in the second half of the nineteenth century (fuelled by industrialization, urbanization, increasing immigration, and a growing eugenics movement) and reflected growing anxieties surrounding social degeneration of all types.

While the combination of wealth, status and femininity was perceived, as Pernick has suggested, to “breed a truly exquisite sensitivity,” perceptions of whiteness also shaped beliefs about which women experienced the highest levels of pain in giving birth.<sup>84</sup> As postcolonial and feminist scholars alike demonstrate, ideas about whiteness and which individuals could be classified as racial others were constantly in flux, and inseparable from the wider social and cultural environment.<sup>85</sup> Irish women, for example, due in part to their association with the working classes, but also arising from their perceived “ethnic” background, were thought to experience less pain in giving birth than English women and women of other northern European nations. Melendy, writing in the *Ladies Home Companion*, constructed these hierarchies in making this point to her expectant readers. In a statement that highlights some of the inherent problems with attempting to tease out the respective influences of race, class, and gender, Melendy asserted that Irish women “live on a diet of potatoes and cabbage” and described their confinements as lasting “only from one to three hours in duration, with very little pain.”<sup>86</sup> Here, through highlighting the differences in sensitivity for various female bodies,

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<sup>84</sup> Pernick, *A Calculus of Suffering*, p. 151.

<sup>85</sup> Adele Perry, for example, has demonstrated that “whiteness is an especially slippery yet significant racial category.” Adele Perry, *On the Edge of Empire: Gender, Race, and the Making of British Columbia, 1849-1871* (Toronto: University of Toronto Press, 2001), p. 5.

<sup>86</sup> Melendy, *Ladies Home Companion*, p. 133.

women of Irish descent were constructed in a way that made them both less “delicate” and less white than their Anglo-American counterparts.

In popular advice literature published throughout English-speaking North America, the increasingly delicate bodies and painful labours of white women were most often contrasted with the more natural bodies and births of so-called “savage” women who were thought to experience little or no pain in parturition. While the class of the women in question played a secondary role in these discussions of a racialized sensitivity to pain, and was seldom made explicit, medical experts routinely inferred that the white women in question were the well-to-do “luxurious daughters of artificial life” singled out in much of the advice literature of the period. As in much of the medical texts and professional journals published throughout the late nineteenth and early twentieth centuries, the term savage was regularly, in the Canadian context, associated with the historically-contingent term “Indian” in referring to Aboriginal peoples whose decreased pain perception was often attributed to an inferior level of civilization. In the prescriptive volumes they authored and directed at expectant mothers, physicians often relied on a similar set of anecdotes, case examples, and motifs, to offer a series of messages about the perceived relationship between race and sensitivity to pain – or, inversely, desensitivity and obstetrical hardiness – to their lay audiences.<sup>87</sup>

While the expectant readers of advice literature were routinely and bluntly told that “the first symptom of real labour is pain,” descriptions of so-called “savage” births

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<sup>87</sup> See Hoberman, “The Primitive Pelvis.”

offered lay audiences a very different picture of parturition.<sup>88</sup> Melendy, in her *Ladies Home Companion*, advised female audiences that “all animals which are left to instinct and nature, bring their young into the world without suffering,” and included the suggestion that “among Indians the squaws do not suffer in childbirth. They will step aside from the ranks even on the march, and return in a short time, bearing with them the new-born child.”<sup>89</sup> Stockham echoed such assertions in her own volume, noting that “the squaws of [American] Indian tribes experience almost no suffering in childbirth...the function scarcely interferes with the habits, pleasures, or duties of life.”<sup>90</sup> She also suggested that white infants (like their mothers) were increasingly fragile, and that while “an Indian papoose might be plunged into water at once [following delivery] without detriment,” she advised mothers that “no white baby of this country has sufficient vitality to safely undergo this shock.”<sup>91</sup> Echoing widely held attitudes, M.L. Holbrook explained to his readers that the lower level of pain experienced by such “savage” women was due to the fact that they “live much in the open air, take much exercise,” and were “physically active and healthy to a degree greatly beyond their more civilized sisters.” Holbrook went on to suggest that “these instances prove that parturition is likely to be painless in proportion as the mother is physically perfect, and in a perfect condition of health.”<sup>92</sup>

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<sup>88</sup> *The Ladies Physician: A Guide for Women in the Treatment of their Ailments, By a London Physician* (London: Cassel and Company, Ltd., 1886), p. 256.

<sup>89</sup> Melendy, *Ladies Home Companion*, pp. 131, 132.

<sup>90</sup> Stockham, *Tokology*, p. 17. In 1887 Dr. Prudence B. Saur of Philadelphia, made a similar point, suggesting that “there is abundant reason for believing that among some savage races neither pregnancy nor labor interrupts the usual avocations and movements of the mother, except, perhaps, for an hour or two at the birth itself.” Saur, *Maternity: A Book for Every Wife and Mother*, p. 196.

<sup>91</sup> Stockham, *Tokology*, p. 180.

<sup>92</sup> Holbrook, *Parturition without Pain*, p. 19. Holbrook implies that these women adhered to a more “natural” and proper regimen than their urban counterparts. These arguments were reprinted in several other works, including volumes from Melendy and Saur.



These themes suffused much of the professional and popular medical discourse of the period and prompted assertions that there was “no country, no tribe, no class, where childbirth is attended with so much pain and trouble as in this country [the United States].”<sup>93</sup> Such images were a recurring feature of descriptions of Aboriginal birth, well into the twentieth century. As late as 1932, Canadian experts, including H.B. Atlee, advised lay audiences that though “this maternity problem is not a simple one for the civilized woman,” the same could not be said for her Indigenous counterparts:

In the aboriginal state child-bearing was a physiological process, and a woman had no trouble bearing her young and little more in raising them than a she-wolf or a lioness. But civilization has robbed a woman of so much physical strength and toughness that childbearing is now a pathological process, and will so remain until by artifice she has recovered through what civilization she lost.<sup>94</sup>

Racialized messages about pain in childbirth, although cloaked in language that emphasized the scientific objectivity of medical knowledge about the female body, served a decidedly social purpose – establishing and reinforcing the racial hierarchies and boundaries of the late-Victorian years. Social distinctions became even more significant in the face of increased immigration and eugenic tensions during the pre-First World War period.<sup>95</sup> While the late-Victorian period saw increasing concern over the delicate nature of white, middle-class women, it was the growing fragility of white infants, held up as the hope for the continuing survival and dominance of the Anglo-Saxon race, that emerged as a persistent cause for anxiety in the early twentieth century.<sup>96</sup> This was all the more true

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<sup>93</sup> Stockham, *Tokology*, p. 17.

<sup>94</sup> H. Benge Atlee, “The Menace of Maternity,” *Canadian Home Journal* (May 1932), p. 8.

<sup>95</sup> See McLaren, *Our Own Master Race*.

<sup>96</sup> Turn-of-the-century Canadians were anxious about declining birth rates and increasing infant and maternal mortality. Coupled with ever-increasing immigration and concern over the high

in the years following the First World War. Nevertheless, given continuing attention to high rates of maternal mortality, physicians continued to emphasize the significance of maternal health during pregnancy and expert care during childbirth, with experts arguing that the mother remained the greatest ally of Canada's young "infant soldiers."<sup>97</sup>

Chavasse's advice manual reflected these concerns in his message that white women hailing from the well-to-do classes were more likely to deliver stillborn children, and that surviving Anglo-Saxon infants were less healthy and more likely to succumb to disease and high rates of infant mortality.<sup>98</sup> Concern over delivering healthy infants, coupled with physicians' recognition that childbirth was increasingly "feared by many women on account of its suffering and hardships," a theme that will be further explored in the following chapter, prompted ever greater use of anaesthesia, as medical advice literature suggested a link between removing women's pain during parturition and safeguarding both motherhood and the race.<sup>99</sup> Despite earlier debates over the safety and morality of anaesthetizing women during delivery, discussed in Chapter 3, by the late nineteenth century anaesthesia's use was significantly less circumscribed.<sup>100</sup> Echoing arguments about the physiological benefits of relieving pain, the physician-authors of advice literature, including M.L. Holbrook, advised their lay readers that medical experts widely believed that white, middle-class childbirth presented a situation "where pain is

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breeding rates of "other" races (including French Canadians) the health of the English-Canadian "race" appeared to be in unprecedented danger. Beaujot and McQuillan, "The Social Effects of Demographic Change", and McLaren, *Our Own Master Race*, p. 9.

<sup>97</sup> W.W. Chipman, "The Infant Soldier," *Social Welfare* 4, no. 3 (1921), p. 49.

<sup>98</sup> Chavasse, *Advice to a Wife*, pp. 230-231.

<sup>99</sup> Melendy, *Ladies Home Companion*, p. 8.

<sup>100</sup> See Shepard, *Watching Closely those who Sleep*, p. 3; Chavasse, *Advice to a Wife*, pp. 224, 226; and Napheys, *The Physical Life of Woman*, p. 197.

likely to do more harm to the nervous system than the anaesthetic could possibly do.”<sup>101</sup> Anaesthetic relief was perceived as particularly necessary for first-time mothers, and by the First World War, physicians publicly emphasized the eugenic benefits of pain relief.<sup>102</sup> In 1916, New York physician J. Clifton Edgar, for example, asserted in a piece published by the *Canada Lancet* that “eventually an established method of painless labour may be considered among public health questions” and had the potential to “limit birth control and criminal abortion.”<sup>103</sup> These arguments about the benefits of anaesthesia, built upon discourses that emphasized the increasingly delicate and sensitive bodies of white, middle-class women, fundamentally served to increase physicians’ authority in the emerging field of obstetrics.

Of course, the expertise of the physician was a recurring theme throughout all of these discussions. Given the changing status of obstetrics as an emerging medical specialty throughout these transformative decades, this emphasis is by no means surprising. The physician-authors of advice literature consistently recommended that their readers obtain “professional aid” at the first sign of any disturbances or “affections” of the womb,<sup>104</sup> and this foregrounding of professional medical expertise continued in their descriptions of how women should approach pregnancy and birth. Lay audiences were advised to avoid brushing aside some of the most common “symptoms” of pregnancy including morning sickness and heartburn, and were prompted instead to seek medical

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<sup>101</sup> Holbrook, *Parturition without Pain*, p. 66.

<sup>102</sup> Scovil, *Preparation for Motherhood*, pp. 263, 265. Dr. Elisabeth Scovil also notes that “the young expectant mother” (presumably, the primiparous mother) was the most anxious patient, requiring the greatest reassurance and medical care.”

<sup>103</sup> “Painless Labor,” *CL* 50 (January 1916), p. 218.

<sup>104</sup> *Every Woman Her Own Doctor*, pp. 222-223.

treatment for these ailments.<sup>105</sup> By counselling expectant patients that the presence of the husband or “any attendants” aside from the doctor during labour was “not only unnecessary but injurious,” physician-authors exerted even greater control over the events taking place in the birthing room.<sup>106</sup> This authority was continuously reinforced by emphases on the fact that the licensed physician was the only practitioner qualified, without exception, to administer anaesthetic relief to parturient patients.<sup>107</sup> Into the twentieth century, expectant mothers were told to turn to the physician – and preferably, the family doctor – first for all information, avoiding “silly, gloomy stories or ‘old wives’ fables.”<sup>108</sup> These messages were reinforced by the growing emphasis on high rates of maternal and infant mortality during the interwar period, with pregnant women advised of the mounting significance of prenatal care: “it is not enough merely to call a doctor when she is already in labour. She should consult a doctor as soon as she discovers she is pregnant.”<sup>109</sup>

Though childbirth was cast as a difficult period, the expert authors of prescriptive literature simultaneously affirmed that motherhood existed as women’s highest purpose. As a result, those women who did not “to some extent desire to have children” were pathologized in much of the advice literature produced during this period. Holbrook

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<sup>105</sup> Readers were warned that the effects of such symptoms depended “in very great measure upon the health of the mother.” Accordingly, the medical expert was required to step in to both determine and safeguard maternal health, checking “every slight deviation from the natural course of things” with “appropriate dietetic or medical treatment.” *Girlhood and Wifehood*, pp. 167, 255.

<sup>106</sup> Chavasse, *Advice to a Wife on the Management of Her Own Health*, p. 211, Saur, *Maternity: A Book for Every Wife and Mother*, p. 225.

<sup>107</sup> Saur, *Maternity: A Book for Every Wife and Mother*, p. 230.

<sup>108</sup> MacMurchy, *Canadian Mothers’ Book*, pp. 8-10.

<sup>109</sup> Atlee, “The Menace of Maternity,” *CHJ* (1932), p. 84.

described such females as “defective – maimed: just as a person who is unable to take pleasure in music, or who is incapable of distinguishing between right and wrong, or who cannot feel sympathy with the pleasure or pain of other people.”<sup>110</sup> Other physician-authors echoed his assessments, suggesting that “everything in a true woman’s physical nature tends toward maternity, and only with a wrench that does violence to her higher nature and physical well-being, can she tear herself away from it.”<sup>111</sup> As leading Canadian experts including Helen MacMurchy framed motherhood as women’s “greatest happiness,” these messages had acquired unprecedented national significance by the interwar period.<sup>112</sup>

## Conclusion

In late nineteenth and early twentieth century English Canada, prescriptive literature often existed as a crucial point of contact between expectant mothers and the mainstream medical profession. While such works offered physicians an opportunity to articulate their professional expertise, these volumes also contained a series of gendered, class-based, and racialized messages that went hand in hand with the establishment and reinforcement of hierarchies between so-called “delicate” and “natural” women. Well-to-do white women were portrayed and perceived as experiencing heightened pain during

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<sup>110</sup> Holbrook, *Parturition without Pain*, p. 7.

<sup>111</sup> Drake, *Maternity without Suffering*, p. 17. Marion Harland argued that “there is something awry in the sensibilities, or off of the balance in the brain of the wedded woman who, although moderately healthy and not actually poor, elects never to be a mother.” Harland, *Eve’s Daughters*, p. 314.

<sup>112</sup> MacMurchy, *Canadian Mother’s Book*, p. 6.

childbirth for a number of historically-specific reasons, demonstrating that although individual experiences of pain are always subjective, historians can learn much about the sociocultural milieu by paying attention to the ways in which pain was culturally framed, constructed, and understood. The delicate woman was a common trope in much of the advice literature produced at the turn of the century, and, as will be discussed in the following chapter, the anxieties that underlay this image also resonated in women's own attitudes towards childbearing.

## Chapter 5

### **“When I Think of What is Before Me, I Feel Afraid”:**

#### **Popular Attitudes toward Pregnancy, Parturition, and Pain**

In the late 1860s, while expecting her first child, Lucy Ronalds Harris, a young newlywed from a respectable London, Ontario family, confessed in her diary, “I half fear that July [the month during which she was expected to give birth] will be the end for me... I think I shall not recover.”<sup>1</sup> Although Harris did “recover” after having her first child, and ultimately went on to deliver four more children, her memories of fear and anxiety about giving birth marred her subsequent pregnancies. While in the first trimester of her fifth and final pregnancy in 1880, she still remarked, “when I think of what is before me, I feel afraid.”<sup>2</sup>

Harris’ emotions during her pregnancy and feelings towards her coming delivery were representative of those of many women during the late nineteenth and early twentieth centuries. This chapter takes Harris’ account, along with others found in the private writings of English-Canadian women, as a starting point to examine public attitudes towards women’s bodies and childbirth pain throughout this period. The majority of perspectives discussed in this chapter are those of expectant mothers, who were more likely than men to record their feelings towards pregnancy and birth at the turn of the twentieth century. Nevertheless, I do attempt to highlight evidence that

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<sup>1</sup> Diary of Lucy Ronalds Harris, 28 February 1868, in *The Eldon House Diaries: Five Women’s Views of the Nineteenth Century*. Edited and with an Introduction by Robin S. Harris and Terry G. Harris (Toronto: University of Toronto Press and The Champlain Society, 1994), p. 424.

<sup>2</sup> Diary of Lucy Ronalds Harris, 24 March 1880.

suggests how new and prospective fathers, and other men outside of the medical profession, saw pregnancy and birth during this particular historical moment.

As was the case in much of the western world, the second half of the nineteenth century was a time of intensive socioeconomic change in Canada. As women became increasingly visible and active in the public realm, the middle class sought to preserve its status, and immigration reached unprecedented levels, gender, class, and racial tensions intensified. Changing medical and cultural perceptions of the female body were one expression of these heightened social anxieties. During the mid-to-late Victorian years, the trope of the “delicate” middle or upper-class white woman, highly “evolved” and therefore increasingly sensitive to pain, became commonplace in both medical and public discourses. As has been discussed in the previous chapters, in the limited obstetrical training they received, the professional journals they read and produced, and the advice literature they published and promoted for young wives and expectant mothers, the majority of English-Canadian physicians articulated and supported perceptions of an increasingly delicate white female body. These doctors also asserted that this rapidly growing group of women, referred to in advice volumes by physician M.L. Holbrook as “the luxurious daughters of artificial life,” were apt to face new levels of pain in giving birth.<sup>3</sup> In this atmosphere, it is understandable that giving birth, historically the heart of womanly culture, came to be shrouded in growing levels of fear and anxiety, paving the way for its increasing medicalization and domination by male physicians.

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<sup>3</sup> Holbrook, *Parturition without Pain*, p. 17.



English-Canadian women such as Lucy Ronalds Harris appear to have internalized these ideas, as much as this can be measured in their personal writings. In the diaries and personal correspondence they left behind, they narrated their bodies and birthing experiences in ways that conformed to prevailing medical discourses. Medicalized descriptions of the “delicate” female body and women’s increased sensitivity both reflected and reinforced middle-class women’s anticipatory fear of the pain of giving birth, and markedly shaped individual recollections of birthing experiences. These pervasive anxieties contributed fundamentally to some women’s growing distrust of traditional female support networks and fuelled their increasing recourse to “modern” physician assistance during the birthing process. The outcome was a different personal experience of pregnancy and birth for middle-class white women, the ongoing elimination of midwife attendance, and the growing professionalization of obstetrics in English Canada.

The private lives and experiences of women interested many early historians of emotion. One of those prominent in the field, William Reddy, has recently pointed out that the subdisciplines of the history of emotions and women’s history evolved along parallel lines. In fact, some of the first researchers to become interested in the history of emotions were historians of gender and women, “largely because women had always been considered more emotional than men.”<sup>4</sup> More recently, leading scholars in the field have conceptualized the history of emotions not as a distinct and separate specialization, “but as a means of integrating the category of emotion into social, cultural, and political

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<sup>4</sup> William Reddy, in Jan Plamper “The History of Emotions: An Interview with William Reddy, Barbara Rosenwein, and Peter Stearns,” *History and Theory*, 49 (May 2010), p. 238.

history, emulating the rise of gender as an analytical category since its early beginnings as ‘women’s history’ in the 1970s.”<sup>5</sup> In other words, the history of emotions is an analytical tool – a particular “way of doing” political, social, and cultural history – rather than “something to be added to existing fields.”<sup>6</sup> Focusing on the emotions is undoubtedly a valuable strategy for gender and women’s historians, but scholars in these fields need to be mindful to avoid unintentionally highlighting and perpetuating the stereotype of women as hyper-emotional.

This study of English-Canadian women’s private narratives of fear, pain, and childbirth contributes to the still embryonic historiography on emotion and pain by exploring one specific contextual example of the ambiguous relationship between the two. Though emotions such as fear, anger, and happiness are universally central to the human experience – if not, however, universally experienced by individuals in different cultures – analysis of emotions has, as Joanna Bourke notes, “remained peripheral to the historical discipline.”<sup>7</sup> As Bourke argues, the experiences of and rhetoric surrounding emotions such as fear are “an expression of power relations. Emotions link the individual with the social in dynamic ways. They are always about social enaction.”<sup>8</sup> Bourke points out that, of all the emotions, fear is fundamentally about and rooted in “the body – its fleshiness and precariousness.”<sup>9</sup> Nineteenth century fears of live burial, dissection, and untimely and unrespectable death have transformed into twentieth century anxieties

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<sup>5</sup> Jan Plamper, “The History of Emotions,” pp. 237-65.

<sup>6</sup> Reddy, in Plamper, “The History of Emotions,” p. 49.

<sup>7</sup> Joanna Bourke, “Fear and Anxiety: Writing about Emotion in Modern History,” *History Workshop Journal*, 55 (2003), pp. 112-113.

<sup>8</sup> Bourke, “Fear and Anxiety,” p. 113.

<sup>9</sup> Joanna Bourke, *Fear: A Cultural History* (London: Virago Press, 2005), p. 8.

surrounding the bodily pains and discomforts of disease, cancer, and old age, but over the years, the body has remained a central site and focus point of human fears.<sup>10</sup>

Late nineteenth and early twentieth century anxieties about pain and parturition fit into this framework of body-centred fear. In their shared fears and anxieties about the pain of giving birth, middle-class white women formed what Barbara Rosenwein classifies as an “emotional community” – a group of people “animated by common or similar interests, values, and emotional styles and valuations.”<sup>11</sup> Like other proponents of the cognitive theory of emotions, Rosenwein argues that emotional responses “are about things judged important to us” and “are the result of our values and assessments.”<sup>12</sup> Women’s fears during pregnancy and anxieties surrounding an upcoming birth, then, are a reflection of the significance of a maternal identity for women during the Victorian period.<sup>13</sup> This significance also ascribed a unique meaning to labour pain. Effecting a

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<sup>10</sup> Bourke, “Fear and Anxiety,” p. 118, and *Fear: A Cultural History*.

<sup>11</sup> When she initially coined the term in 2002, Rosenwein defined “emotional communities” as “precisely the same as social communities – families, neighborhoods, parliaments, guilds, monasteries, parish church memberships,” and went on to suggest that researchers examining such communities seek to uncover “systems of feeling: what these communities (and the individuals within them) define and assess as valuable or harmful to them; the evaluations that they make about others’ emotions; the nature of the affective bonds between people that they recognize; and the modes of emotional expression that they expect, encourage, tolerate, and deplore.” Rosenwein also asserted the fluid nature of these communities, and argued that “people moved (and move) continually from one such community to another... adjusting their emotional displays and their judgements of weal and woe to these different environments.” Barbara H. Rosenwein, “Worrying about Emotions in History,” *American Historical Review* 107, no. 3 (June 2002), p. 842. Rosenwein offered a more succinct definition, stating that emotional communities are “social groups that adhere to the same valuations of emotions and how they should be expressed” or “groups of people animated by common or similar interests, values, and emotional styles and valuations,” in a 2010 interview with Jan Plamper. Barbara Rosenwein in Plamper, “The History of Emotions,” p. 253.

<sup>12</sup> Rosenwein in Plamper, “The History of Emotions,” p. 251.

<sup>13</sup> The fact that motherhood existed at “the apex of a Victorian bourgeois ideal” and was of the utmost emotional significance to many women is a point that has been identified by a host of historians of women’s health, sexuality, and childbirth. See Marland, “Languages and Landscapes of Emotion,” p. 53. Though Marland’s study focused on England, motherhood was central to middle-class femininity for women in Victorian Britain, Canada, and the United States.

visible change on the female body – and therefore, according to Elaine Scarry, all the more likely to be treated – the pain of giving birth increasingly represented, in the words of one physician, “a public health question” and an obstacle that prevented white, middle-class women from fulfilling their maternal true purpose.<sup>14</sup> This pain, then, threatened the health and vitality of the Anglo-Canadian race.

Women’s diaries and personal correspondence offer a particularly valuable viewpoint into private and individual experiences of fear, anxiety, and pain within this particular emotional community, but these types of sources have their own well-worn methodological considerations. Scholars have argued that women’s personal narratives suggest “how women negotiate their ‘exceptional’ gender status both in their daily lives and over the course of a lifetime.”<sup>15</sup> Historians, in particular, consider that diaries provide rare “accounts of domains that need to be better understood,” and are the most important window into women’s experiences of some of the “key moments” of domesticity, including birth.<sup>16</sup> Yet these documents also “recount a process of construction of the self,” and accordingly, are always mediated to a certain extent by the diary-keeper.<sup>17</sup> This personal mediation shaped the entries in the individual diaries discussed in this chapter, for some women more than others. Lucy Ronalds Harris’ stepmother, Amelia Ryerse Harris, for example, was well aware that her diary had an audience, was read by relatives, and often served as a forum for wider family discussions.<sup>18</sup> For other women, diary

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<sup>14</sup> Scarry, *The Body in Pain*, p. 12; Edgar, “Painless Labor,” *CL* (1916), p. 218.

<sup>15</sup> *Interpreting Women’s Lives: Feminist Theory and Personal Narratives*, ed. The Personal Narratives Group (Bloomington and Indianapolis: Indiana University Press, 1989), pp. 4-5.

<sup>16</sup> Harris and Harris, *The Eldon House Diaries*, xxi.

<sup>17</sup> *Interpreting Women’s Lives*, p. 5.

<sup>18</sup> Harris and Harris assert that this diary, in particular, rather than offering a mere personal record of events and private thoughts, “played a didactic role and was intended to instruct, sensitize, and

entries were shaped by time, as they “wrote backwards” to make up for weeks or months of missed diary-keeping after events such as delivering a child, or they treated their journals as the site for year-end recaps of goings-on in the family.<sup>19</sup> Women’s memories of pregnancy and parturition were also, of course, mediated by the pain of giving birth. As one scholar has recently argued, traumatic events – including, I would suggest, the childbirth experience – are characterized by their “inability to be integrated into one’s normal patterns of meaning-making” as memories are moulded by traumatic experience.<sup>20</sup>

Aside from intercessions by the diary-keeper, diary writings were also mediated by the wider cultural milieu, and scholars have aptly identified that these narratives are “materially and socially situated.”<sup>21</sup> Diary entries, then, are not simply reflections of lived realities, but rather, offer “nuanced commentaries on the cultural context[s] in which

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even direct family members according to Amelia’s wishes.” In her diary entries, Amelia Ryerse Harris made several comments to this end, writing most explicitly on 4 June 1859, “My journal came under discussion.” The fact that Harris knew her diary was read by others and was, in effect, “up for discussion”, undoubtedly shaped the nature and tone of her entries. Harris and Harris, *The Eldon House Diaries*, xxv, p. 113. Kathryn Carter has argued that many diaries were, in fact, “semi-public documents. They did (and do) circulate. The relationship between diaries and their deliberate or accidental audiences sets diaries apart from other forms of published writing.” Kathryn Carter, *The Small Details of Life: Twenty Diaries by Women in Canada, 1830-1996* (Toronto: University of Toronto Press, 2002), p. 13.

<sup>19</sup> After a period with no diary entries, Eliza Jane Wilson of Western Canada wrote on 9 January 1904, “I have quite a diary write up. Almost 3 weeks I will write backwards, it will be easier.” Diary of Eliza Jane Wilson, 9 January 1904, Eliza Jane Wilson Fonds, 1901-1958, M 1320, Glenbow Museum and Archives. At the end of 1878, Jennie Curran of Orillia, Ontario wrote that “another year is near its close and I think of my old friend and long to express my thanks to god for the mercies of another year.” Curran’s particular habit of year-end entries speaks to the blurred and ambiguous nature of women’s private writing practices, as she tends to treat her diary more as a memoir and a place to record exceptional life-events after they have occurred. Diary of Jennie Curran, 28 December 1878, JEG Curran Fonds, MG 30 C85, Library and Archives Canada.

<sup>20</sup> Michael S. Roth, *Memory, Trauma and History: Essays on Living with the Past* (New York: Columbia University Press, 2012), xviii.

<sup>21</sup> Carter, *The Small Details of Life*, p. 22.

women were required to function.”<sup>22</sup> On a more basic level, these sources typically speak to the views of particular groups of women, and are by no means representative of all Canadian experiences. Keeping a diary demanded basic literacy, which, throughout the nineteenth century, often had the potential to exclude many of those women and men of the working classes. Additionally, diary writing during the late-Victorian years was “associated with a genteel life and an ideology of refinement.”<sup>23</sup> The practice became a way to “indicate class standing” and tended to exclude most members of the working class as well as middle-class men who worked outside of the home. Diary writing during this period, for the most part, “marked women of leisure.”<sup>24</sup> Nevertheless, such sources are often deeply rooted in “the desire to transcend one’s own perspective, to find consolation in mutual company, or to give meaning to personal experiences” – as such, they hold enormous value for the historian studying emotions and bodily sensations including pain.<sup>25</sup>

As a result of the limited nature of diary keeping throughout much of the period under study, the diaries examined in this chapter are all written by white, English-Canadian women who can be identified as members of the “respectable” middle and upper classes.<sup>26</sup> These women, as was typical during this period, were generally reticent to discuss pregnancy and childbirth.<sup>27</sup> This reluctance may have stemmed from a variety

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<sup>22</sup> Harris and Harris, *The Eldon House Diaries*, xxii.

<sup>23</sup> Carter, *The Small Details of Life*, p. 15.

<sup>24</sup> Carter, *The Small Details of Life*, p. 15.

<sup>25</sup> Moscoso, *Pain: A Cultural History*, p. 3.

<sup>26</sup> I came to this conclusion based on individual entries referring to various elements of what can only be described as a “comfortable” lifestyle – descriptions of frequent parties, extensive travel, elaborate houses, and reference to domestic workers were the norm for these women.

<sup>27</sup> In her examination of the American context, Jacqueline Wolf suggested that many women did not mention a pregnancy until after giving birth. I have found the same to be true for some

of factors. First and foremost, taboos surrounding public displays and discussions of pregnancy could be a pervasive part of late nineteenth and early twentieth century Canadian culture. In an 1887 diary entry, Emma Laflamme of Winchester, Ontario, recounted that a friend, expecting “an increase of the family sometime in the near future,” would, “under the circumstances,” feel “out of place” at a dinner party.<sup>28</sup> Sarah Kroeker, of Steinbach, Manitoba, kept her own 1920 pregnancy a secret for as long as she found possible, remembering that “in those days...things like that weren’t talked too freely about.”<sup>29</sup> These views appear to have been shared by women and men alike. Toronto-trained physician Clifford Hugh Smylie, later describing his own wife’s first pregnancy in 1923 in his unpublished personal memoirs, recalled that during this period, the two no longer went on evening walks. He commented, “pregnant women didn’t go out in public more than necessary. Her condition must be kept from public view.”<sup>30</sup> For some women, then, it is likely that discussing pregnancy and reproduction, even in a diary, may have pushed the limits of Victorian feminine respectability. Second, many women would have been aware of the potential and realities of losing a pregnancy in the early stages. Finally, though physicians increasingly pathologized both pregnancy and birth, historians have argued that, at the same time, many medical men considered gravidity to be the “normal” and unremarkable state for the married woman.<sup>31</sup> For those women who experienced

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Canadian women, but their writings are, understandably, of less interest in this chapter. Wolf, *Deliver Me from Pain*, p. 31.

<sup>28</sup> Diary of Emma Laflamme, 1 January 1887. Toronto Reference Library, Special Collections, Baldwin Room.

<sup>29</sup> Marie Reimer of southern Manitoba made similar comments in recalling her own pregnancy in the 1920s. Heidi Harms and Katherine Martens, *In Her Own Voice: Childbirth Stories from Mennonite Women* (Winnipeg: University of Manitoba Press, 1997), pp. 29-30, 36.

<sup>30</sup> *Personal Memoirs*, Clifford Hugh Smylie Fonds, p. 148

<sup>31</sup> In her study of the nineteenth century medical practice of Ontario practitioner Dr. James Miles Langstaff, Jacalyn Duffin suggests that the fact that “pregnancy seems to have been considered

several pregnancies throughout their reproductive lives, then, these episodes may have been unworthy of comment. While it is difficult for the historian to weigh the respective influences of each of these factors, the end result is that oftentimes, only cursory references to individual experiences of the major life events of pregnancy and birth made their way into women's private writings, and accordingly, the historical record. Despite these limitations, as Judith Walzer Leavitt has argued, fear of childbirth was a common anxiety for women during the nineteenth and early twentieth centuries: "Rich, poor, urban and rural women all shared with each other, by virtue of their sex, an enormous bond of common experience... Owing to their common physical and social experience, women developed similar feelings, fears, and needs during pregnancy and delivery, despite their divergent life circumstances."<sup>32</sup>

### Fears of Pain, Pains of Fear

Women's fears about the pain and suffering associated with giving birth were often accompanied by fears of invalidism following delivery.<sup>33</sup> More importantly, in the context of growing emphasis on high rates of maternal and infant mortality into the

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the normal state for a married woman" contributed to the doctor's lack of discussion of obstetric cases in his patient casebooks. Duffin, *Langstaff: A Nineteenth-Century Medical Life*, p. 183.

<sup>32</sup> Judith Walzer Leavitt and Whitney Walton, "'Down to Death's Door': Women's Perceptions of Childbirth in America," *Women and Health in America: Historical Readings*, ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1984), pp. 155-165, 156. See also Mitchinson, *Giving Birth in Canada*.

<sup>33</sup> The risks of invalidism in the post-partum period continued to be emphasized by Canadian physicians in mainstream medical literature into the mid-twentieth century. A 1940 piece in the *CPHJ*, for example, included the comments: "Death is not the only peril on the uncharted voyage of motherhood when taken without a pilot. Too often the mother becomes a chronic invalid after childbirth or her strength is severely sapped." Jackson, Rawson, and Couture, "Maternal Mortality in Manitoba," *CPHJ* (1940), p. 321.



interwar period, they feared that they or their newborn infants could face death in the birthing room. These anxieties made the whole pregnancy a particularly tense time for many women. The fact that these emotions tended to characterize the entire nine-month period goes hand in hand with the expansive definitions these women had for the pains and discomforts of pregnancy and the act of giving birth. For the women authors of these diaries, the pain of giving birth *was* emotional, and often inseparable from the wider uncertainties, anxieties and fears of the entire duration of the pregnancy. The diaries of Lucy Maud Montgomery, the internationally-known children's author made famous by her *Anne of Green Gables* stories, in many ways, encapsulate this relationship. Though Montgomery, like other diarists, practiced what literary scholar Irene Gammel has referred to as "retrospective disclosure," rewriting and reframing events after they had occurred, and treating her personal writings a site where "she consciously and carefully crafted her life, for posterity, as a literary and cultural artifact," her journals remain a valuable source for historians given the absence of other records in which Canadian women recorded their views on pregnancy and birth.<sup>34</sup>

For Montgomery, the many uncertainties associated with childbearing, coupled with the increasing bodily discomforts of gestation, led her to declare in the final weeks of her first pregnancy in 1912, "I really suffer a martyrdom of misery, partly physical, partly anxious."<sup>35</sup> This "misery" extended well beyond the actual birth and arose out of both her anxieties and corporal complaints, blurring the lines between emotional and

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<sup>34</sup> Irene Gammel, "Life Writing as Masquerade: The Many Faces of L.M. Montgomery," in *The Intimate Life of L.M. Montgomery* (Toronto: University of Toronto Press, 2005), pp. 3, 8.

<sup>35</sup> *The Selected Journals of L.M. Montgomery, Volume II: 1910-1920*, eds. Mary Rubio and Elizabeth Waterson (Toronto: Oxford University Press, 1987), 30 April 1912.

physical sufferings. In consistently discussing the pain and discomforts of pregnancy and childbirth using emotionally-charged language, Montgomery and the other diarists challenge what David B. Morris has referred to as the “Myth of Two Pains” – the idea that pain can be logically divided into two separate types, physical, and emotional or mental.<sup>36</sup> This rhetoric was not limited to expectant mothers. On some occasions – including, for example, in the professional medical debates as to whether or not to administer anaesthetics or analgesics during the first stage of labour, based on considerations of both the general condition of the patient and an expert medical assessment of “whether she is suffering from pain or only from anxiety and the dread of the ordeal in front of her” – physicians also highlighted a similar relationship between physical and emotional pain.<sup>37</sup> Still, an examination of English-Canadian women’s emotional responses to the discomforts of gestation and childbearing, over the course of the pregnancy – as well as, to a lesser extent, men’s responses to pregnancy and anxieties surrounding the events taking place in the birthing room – contributes to a growing body of scholarship that seeks to collapse the artificial divisions between emotional and physical pain.

Though many of the women discussed in this chapter framed their pregnancies as shaped by fear, uncertainty, and anxiety, these “negative” emotions were often tempered by “positive” feelings of excitement and joy towards the birth of a new child. While these feelings prompted some women, including Montgomery, to record excitedly the discovery of a pregnancy in a diary, veiled references to pregnancy and later allusions to

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<sup>36</sup> David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991), p. 9.

<sup>37</sup> McIlroy, “Analgesia and Anaesthesia in Childbirth,” *CMAJ* (1931), p. 22.

the fact that a child might be expected in the near future were more common.<sup>38</sup> Frances Tweedie Milne of Whitby, Ontario, for example, made note in the margins of her diary in January 1870 that “courses should have come on last” before Christmas the previous month. In mid-February, she made a similar note that she “went to church... courses should have cm [come].” During her second trimester, references to the “little gown” and “little clothes” she sewed and showed to a friend suggested the coming addition to the family.<sup>39</sup> Similarly, western Canadian homesteader Eliza Jane Wilson commented that she “found the basin in the bedroom empty and clean... rather unusual” in late-August 1903, but did not admit to “getting... ready for the new addition” until November 30.<sup>40</sup>

The fear of losing a pregnancy in its early stages might have contributed to such self-censorship, but it also prompted other women to record the anxieties that surrounded a new pregnancy. After miscarrying in the spring of 1919, Gwyneth Logan of Vancouver, British Columbia wrote to her husband Harry who was working in Ottawa, Ontario, in the fall, during the first trimester of a new pregnancy: “I can’t help feeling nervy after last time. I shall be thankful when the next month is safely over”, “these are critical days... I can’t help being anxious.”<sup>41</sup> The precariousness of pregnancy meant that Logan, like other women during the period, often trod carefully during these months. After

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<sup>38</sup> Montgomery excitedly and famously proclaimed on 28 January 1912, “I want to have a child... something to link me with the future of my race.” *Selected Journals of L.M. Montgomery*.

<sup>39</sup> Diary of Frances Tweedie Milne, entries 14 January 1870, 13 February 1870, 9 June 1870, 11 June 1870, 26 August 1870, Frances Tweedie Milne Papers, MU 866, Archives of Ontario.

<sup>40</sup> Wilson was living near Calgary in Dorothy, Alberta. Diary of Eliza Jane Wilson, Entries 27 August 1903, 30 November 1903, Glenbow Museum and Archives.

<sup>41</sup> The Logan correspondence is a remarkable source, detailing the courtship and married life of Gwyneth (Murray) Logan and her husband, Harry Logan, for a period of more than a decade. Letters from Gwyneth Logan to Harry Logan, 6 October 1919, 28 October 1919, Harry Tremaine Logan and Family Fonds, MG 30 C215, Library and Archives Canada.

experiencing repeated spotting and going on bed rest, Logan complained and described herself as “a semi-invalid.”<sup>42</sup> For working-class women who may have had more considerable domestic responsibilities, the often doctor-prescribed rest associated with pregnancy could have posed a problem.

English-Canadian women also expressed distaste about some of the other physical discomforts associated with pregnancy. Lucy Ronalds Harris wrote of her lack of energy and feeling “unfit for everything except bed” while pregnant with her first child in January 1868.<sup>43</sup> During a subsequent pregnancy, she made note of her “many vexations” and remarked, “no one knows what I suffer.”<sup>44</sup> Eliza Wilson repeatedly mentioned suffering from toothaches and neuralgia, before, during, and after her pregnancy,<sup>45</sup> demonstrating that oftentimes, the various “ailments” associated with pregnancy were, for many women, part of a wider spectrum of longer-term health complaints.

Historians have demonstrated that as the traditional culture of female-dominated childbirth declined in the nineteenth century, giving birth became increasingly “shrouded in mystery” for many American young women.<sup>46</sup> An examination of Canadian women’s private records demonstrates that the uncertainty associated with childbirth was undoubtedly a major cause of anxiety for women north of the border. Pregnant with her

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<sup>42</sup> Gwyneth Logan to Harry Logan, 29 November 1919, LAC.

<sup>43</sup> Diary of Lucy Ronalds Harris, 22 January 1868, *The Eldon House Diaries*.

<sup>44</sup> Diary of Lucy Ronalds Harris, Entries, 22 May 1873, 24 May 1873. *The Eldon House Diaries*. These entries were written in the final months of Harris’ pregnancy; her first son was born on 15 June 1873.

<sup>45</sup> Diary of Eliza Jane Wilson, Entries 7 October 1901, 19 November 1901, 28 November 1901, 30 November 1901, 23-25 February 1903, 2 October 1903, 27 November 1903, 18 April 1904, 25 May 1904, Glenbow.

<sup>46</sup> Wolf, *Deliver Me From Pain*, p. 20.

first child in 1912, Lucy Maud Montgomery remarked that she felt very nervous when she thought of the ordeal before her, speculating that “it cannot be easy at the best.”<sup>47</sup> For Montgomery, the uncertainty associated with birth was one of her greatest fears. After her delivery, she recounted:

in the dead, dim hours of night, fears and gloomy dreads came to me... they always lurked in the background of my mind. Would I escape with my life? Would I, as some of my friends have done, suffer so dreadfully that the remembrance would always be a horror? Would my child live? These and a score of other fears haunted me.<sup>48</sup>

Somewhat confident that the threat of miscarriage had passed after the end of her first trimester, Gwyneth Logan wrote to her husband, “I don’t believe I shall have any more troubles, but one never knows, that is the worst of this business.”<sup>49</sup> As women approached birth anxious, uncertain, and oftentimes, largely ignorant about their own bodies, physicians’ perceptions “became the dominant view of the nature of birth.”<sup>50</sup> Given the fact that, as discussed in Chapter 1, many physicians may have been less than comfortable in taking on the sole responsibility for conducting deliveries and managing the events taking place in the birthing room, their actions and demeanor at the bedside (which may have, at times, been perceived as unsympathetic by expectant patients) may have well exacerbated women’s anxiety.<sup>51</sup>

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<sup>47</sup> *Selected Journals of L.M. Montgomery*, 4 April 1912.

<sup>48</sup> *Selected Journals of L.M. Montgomery*, 22 September 1912.

<sup>49</sup> Gwyneth Logan to Harry Logan, 12 December 1919, LAC.

<sup>50</sup> Wolf, *Deliver Me from Pain*, p. 42. See also Chapter 4.

<sup>51</sup> As Joanna Bourke demonstrated in her recent study of medical professionalism and sympathy from the eighteenth to the twentieth century, male physicians sought to demonstrate in their practice an active, rational, scientific and “masculine” version of sympathy that was increasingly contrasted with women’s perceived emotional sentimentality. See Joanna Bourke, “Pain,

Given contemporary medical ideas about the delicate female body, many of the English-Canadian diarists also noted their fear of the unknown and reputedly unprecedented pain they would experience in giving birth. Much of the professional and prescriptive literature of the period emphasized that primipara mothers had the longest and most difficult deliveries, and so, first time mothers had reason to suspect that they had the most to fear.<sup>52</sup> Having had no previous children, Montgomery – who, at thirty-seven, was well beyond the age at which even the most “generous” physicians drew the line after which one could be considered an “elderly” mother subject to increasingly complicated (and painful) deliveries<sup>53</sup> – reasoned that the discomforts of pregnancy would be a small price to pay “if it were not for the anguish of the final ordeal.” She continued, “I have never had to endure any intense physical pain. So I fear I shall not bear it well or be very brave or patient... now, when the end is coming so near, I cannot avoid feeling dread and anxiety.”<sup>54</sup> Montgomery’s statement about her suspected lack of stoicism in the face of new levels of pain is particularly interesting. As Lucy Bending has suggested in her study of the representation of pain in nineteenth century England, medical men commonly asserted that “supercivilized” women (of Montgomery’s sort) were particularly apt to “eschew all painful encounters,” behaviour which, in the long

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sympathy and the medical encounter between the mid eighteenth and the mid twentieth centuries,” *Historical Research*, 85, no. 229 (2012), pp. 430-452.

<sup>52</sup> Elisabeth Robinson Scovil noted that “the pains are very severe” and anaesthetic relief was all the more required for first time mothers. Scovil, *Preparation for Motherhood*, p. 265.

<sup>53</sup> Mitchinson has found that some physicians drew this line as early as age 26; others extended the range from age 28-32. See Mitchinson, *Giving Birth in Canada*, p. 162; Edgar, *The Practice of Obstetrics*, p. 66; Williams, *Obstetrics: A Textbook for the Use of Students and Practitioners*, p. 284.

<sup>54</sup> *Selected Journals of L.M. Montgomery*, 22 September 1912.

run, was thought to weaken the female body and render it more susceptible to pain.<sup>55</sup> As this line of reasoning suffused the popular medical discourse of the period, Montgomery may well have been aware of such arguments, and they would have undoubtedly heightened her anxiety.

In her study of childbirth and anaesthesia in the United States, Jacqueline Wolf argues that by the mid-nineteenth century, women's fear of pain during childbirth had equaled their fear of death during the ordeal: the two fears consistently converged, as "women often likened labour pain to a near death experience."<sup>56</sup> This perspective also comes through in the writings of English-Canadian women. In the months before her first delivery in the summer of 1868, Lucy Harris, whose account opened this chapter, remarked that she feared giving birth would result in her death.<sup>57</sup> Such fears were nothing new for the Harris women. After losing one daughter to puerperal fever, Lucy's mother-in-law, Amelia Ryerse Harris, remarked in her own diary eight years earlier that she feared for the life of another, who expected her confinement within days.<sup>58</sup> Montgomery, who wrote at length on her fears of the pain of giving birth, also contemplated her fate, wondering, "Will I pass safely through the valley of the shadow and bring therefrom a new life? Or shall I remain among the shadows? I shall not write in this journal again until all is over. Perhaps I may never write again..."<sup>59</sup> As medical experts recognized, by the interwar period, that they had largely "impressed upon the patients that pregnancy was a pathological rather than a physiological condition," and taught expectant mothers

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<sup>55</sup> Bending, *The Representation of Bodily Pain in Late-Nineteenth Century English Culture*, p. 124.

<sup>56</sup> Wolf, *Deliver Me from Pain*, p. 17.

<sup>57</sup> Diary of Lucy Ronalds Harris, 28 February 1868, *The Eldon House Diaries*.

<sup>58</sup> Diary of Amelia Ryerse Harris, 5 May 1860, *The Eldon House Diaries*.

<sup>59</sup> *The Selected Journals of L.M. Montgomery*, 30 June 1912.

“to look for trouble, rather than to recognize and avoid it,” it is not surprising that these fears continued to mark the pregnancies and births of many women in early twentieth century Canada.<sup>60</sup>

### Seeking Succour in the Medical Profession

To counter some of the vulnerability associated with pregnancy and assuage some of these fears, women had traditionally sought out their own mothers and other female family members and friends who had survived the experience of giving birth. By the second half of the nineteenth century, however, many of these networks were being disrupted by increasing migration and family mobility. Writing from the west coast in 1853, Georgina Bruce Kirkby described her pregnancy in the apparent absence of female kin and company, writing that if anything “could relieve or comfort me under my present very depressing condition of health... it would be a congenial female companion. Every woman needs a companion of her own sex.” She later recalled a two-day visit from a neighbouring woman, “which has quite made me forget myself and my ailments.”<sup>61</sup> Canadian women also made note of these disruptions. Mary Kough Brown, of Hamilton, Ontario, who had immigrated to Canada from England shortly before her 1865 pregnancy, recorded “a most depressed day, sick of waiting and longing for such comfort

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<sup>60</sup> Little, “An Address on Obstetrics During the Past Twenty-Five Years,” *CMAJ* (1924), p. 908.

<sup>61</sup> Though Kirkby was writing from rural California, her experiences would have likely struck a chord with those of many rural Canadian homesteading women. Diary of Georgina Bruce Kirkby, 3 February 1853, *Victorian Women: A Documentary Account of Women's Lives in Nineteenth-Century England, France and the United States*, eds. Erna Oilafson Hellerstein, Leslie Parker Hume, and Karen M. Offen (Stanford: Stanford University Press, 1981), p. 213.



as only a dear mother could give.”<sup>62</sup> Frances Milne, who noted her “missed courses” in the margins of her diary, wrote in the month before her delivery that she was “looking for Whitby people” arriving at the train station, “but disappointed.”<sup>63</sup> Later, in the early twentieth century, Gwyneth Logan wrote frequently of her letters home to her mother in England and consistently reminded her husband in Ottawa that their separation during her anxiety-ridden pregnancy represented “an additional trial.”<sup>64</sup>

As the new century began, Canadian medical experts placed growing emphasis on the role of the physician in guiding this group of parturient women – as well as all expectant mothers, more generally – through these crucial life stages. In a 1909 article in the *Western Canadian Medical Journal*, Thomas Ponton, a doctor practicing in rural Manitoba, recalled the case of one of his obstetric patients, a “little English woman”, whom he attended “in her first labour about six years ago. She consulted me when about 2 months pregnant, told me she was away from all her friends, and knew nothing of what was ahead of her.” Ponton “advised her to lead her ordinary life, take lots of outdoor exercise, and not get scared” about what awaited her in the birthing room. Upon finding the expectant mother out walking with her husband as he plowed the fields a few days later, the doctor was pleased to find that his patient had followed his advice “to the letter.” This particular woman embraced the doctor’s expertise and was seen, as a direct result, as having a successful confinement, delivering with “not even a scratch.”<sup>65</sup> When other women in similar situations turned to friends and relatives for advice, however,

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<sup>62</sup> Mary Kough Brown Journals, 24 January 1865, Brown-Hendry Collection, Hamilton Public Library.

<sup>63</sup> Diary of Frances Tweedie Milne, 10 September 1870, AO.

<sup>64</sup> Gwyneth Logan to Harry Logan, 17 November 1919, LAC.

<sup>65</sup> Ponton, “Obstetrical Experiences in Country Practice,” *WCMJ* (1909), p. 315.

perhaps paying what could be seen as too much attention to old wives tales concerning pregnancy and birth, medical professionals saw the behaviour of their patients as much more damaging, having negative effects on women's experiences in the birthing room.

By the first decades of the twentieth century, leading Canadian practitioners recognized that for many women, pregnancy and childbirth represented not only a physical trial, but a test of the morale of the parturient patient.<sup>66</sup> Prominent international experts in the field of obstetrics, including Joseph B. DeLee, found that modern women routinely awaited birth "with much anxiety and trepidation," and as a result, argued that these patients should be offered "cordial encouragement" from the doctor at every opportunity.<sup>67</sup> Other medical men remarked that such fears were most likely to be experienced by "nervous, highly strung women, particularly in their first labour," and were exacerbated by "dread of the unknown, by what they have heard of the trials of their acquaintances in childbirth, by the constant necessity of artificial aid, and by such circumstances as sympathetic mothers, husbands, and friends, and the concentration of the household on the event in which they, as patients, are playing the part of the leading lady."<sup>68</sup> Women were regularly admonished to avoid paying any heed to the "horror stories" and previous experiences recounted by their female friends and relatives, as physicians recognized that this information had the potential to play a potent role in shaping birth experiences. In the early 1930s, Albertan Dr. C.A. Baragar, for example, recalled the case of a patient in which "the element of morbid expectancy" in terms of how the parturient woman in question anticipated birth was "a factor in a

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<sup>66</sup> Chipman, "Some Conclusions after a Symposium in Obstetrics," *CMAJ* (1924), p. 705.

<sup>67</sup> DeLee, *The Principles and Practice of Obstetrics*, p. 231.

<sup>68</sup> Fairbairn, *Gynaecology with Obstetrics*, p. 344.

breakdown...The patient's mother had died following childbirth. The patient herself was in the thirties, friends had advised her of her risks and she approached her own labour with the fear that she would not survive. Five days afterwards she broke down mentally."<sup>69</sup>

Concerns about the ongoing risks of non-medical information and advice continued into mid-century. A 1947 article published in the *University of Toronto Medical Journal (UTMJ)*, highlighting the various "Psychological Factors Involved in Normal Pregnancy," provides a striking example of physicians' ongoing recognition of the risks posed by women's discussions of the "horrors" associated with giving birth. Recognizing that "women's urge to reproduce the species and the maternal instinct" were often "in direct conflict with fears of pregnancy," Dr. H.S. Wasman suggested that while "the stolid bovine type" of woman demonstrated little in the way of fear of giving birth, the "majority" of women expressed fear and anxiety throughout pregnancy, "especially primiparae during the first trimester."<sup>70</sup> These women, already living "in the midst of anxieties and fears," were particularly susceptible to having this sense of angst and unease "exaggerated by 'old wives' tales' and the ill-advised publicity found in the lay [Canadian] press of the morbidity and mortality associated with having a child."<sup>71</sup>

Wasman continued:

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<sup>69</sup> Baragar, "The Mental Hygiene of the Critical Epochs of Life," *CPHJ* (1932), p. 121.

<sup>70</sup> H.S. Wasman, "Psychological Factors involved in Normal Pregnancy," *UTMJ* 25, no. 2 (November 1947), p. 51.

<sup>71</sup> H. Benge Atlee's "The Menace of Maternity," an article appearing in the May 1932 *Canadian Home Journal*, relying on the central argument that "the women of Canada must be aware of the perils to which their physiological process bring them," is a well-known example of such "ill-advised publicity found in the lay press." Atlee, "The Menace of Maternity," *CHJ* (1932), p. 8.

In few other fields is superstition more rife and ignorance more profound, and with such harmful results. It is notorious that informal gatherings of women tend, as the afternoon goes on, to become obstetric clinics, usually, of course, of the abnormal. Why older women delight in frightening young women pregnant for the first time with obstetric tales of horror, or by solemn but silly admonitions is hard to say.

Such fears, Wasserman suggested, were potentially “mitigated by environment and education” if reproduction were carried out under ideal settings, including a doctor’s close supervision throughout pregnancy, and especially during birth.<sup>72</sup>

Judith Walzer Leavitt has argued that women’s fear of childbirth, pain, and death “eroded the comfortable feelings that women received from their companions during traditional births” and, in part, contributed to their greater willingness to seek out physician assistance.<sup>73</sup> In late nineteenth and early twentieth century English Canada, when these traditional womanly support networks were increasingly fractured or conspicuously absent, middle and upper-class women who could afford the expense were all the more open to the new possibilities offered by physician-assisted birth. For some women, this even meant going to hospital for the birth, ahead of the general Canadian trend.<sup>74</sup> With a husband frequently away in Calgary on “ranching duties,” and after a previous miscarriage, Eliza Wilson, for example, remarked, “I have decided to go to the Hospital on Friday. I hope everything will be all right this time.”<sup>75</sup> Being in a hospital setting may have done little to calm Wilson’s nerves. Even after being admitted, she

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<sup>72</sup> Wassman, “Psychological Factors involved in Normal Pregnancy,” *UTMJ* (1947), p. 52.

<sup>73</sup> Walzer Leavitt and Walton, “Down to Death’s Door,” p. 160.

<sup>74</sup> See, for example, Oppenheimer, “Childbirth in Ontario,” pp. 36-60.

<sup>75</sup> Diary of Eliza Jane Wilson, 20 June 1904, Glenbow.

wrote of her continuing hope that everything was “all right”, and in a statement that again blurs the boundaries between emotional and physical pain, noted that the experience “scares a lady nearly to death.”<sup>76</sup>

As a rural homesteader and recent newcomer to the area, Wilson may have had few alternatives to the hospital. Canadian historian Wendy Mitchinson has pointed out women’s agency in their encounters with physicians and hospital-based birth. On the most basic level, “women often controlled whether and when they would see a physician,” and it is important to keep in mind that “they sometimes supported the increased medicalization of their lives.”<sup>77</sup> Indeed, some women reported that by the early twentieth century, it was seen as a sign of progress “to be able to have one’s babies in the hospital.”<sup>78</sup> When women, influenced by the prevailing discourses of the period, sought out physicians and hospital-based births that were represented and perceived as safer and more “modern”, “women’s agency allied itself with the medical profession.”<sup>79</sup>

However much anxieties and expectations of childbirth pain may have been influenced by medical rhetoric that held that “for the great majority of women in civilized nations, parturition is a period of intense pain,” women did, and continue to, have varying reactions to the unique, private, and highly subjective pain of giving birth.<sup>80</sup> For many, physicians’ predictions of the heightened pain they were expected to experience were

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<sup>76</sup> Diary of Eliza Jane Wilson, 28 June 1904, Glenbow.

<sup>77</sup> Mitchinson, *Giving Birth in Canada*, p. 7.

<sup>78</sup> Harms and Martens, *In Her Own Voice*, p. 40.

<sup>79</sup> Mitchinson, *Giving Birth in Canada*, pp. 301-302.

<sup>80</sup> As discussed in the previous chapters, much of the professional and popular medical discourse of the period consistently asserted that because of their luxurious and unnatural lifestyles and “evolved” sensitivity, white, well-to-do, urban-dwelling women would experience the highest levels of pain in giving birth.

brought to bear, and they recalled their confinements as times coloured by both pain and fear. Mary Kough Brown noted that “a fat healthy boy” was born to her only “after much suffering.”<sup>81</sup> Nellie Bailey Bolton, of Port Simpson, British Columbia, wrote in her diary that she “suffered very much” while delivering a daughter in the fall of 1890.<sup>82</sup> Nearly forty years after the 1894 birth of her first daughter, Alberta homesteader Evelyn Cartier Springett, whose experiences were introduced in Chapter 4, recalled, “during one long horrible night I suffered in silence... I shall never forget those awful hours.”<sup>83</sup> Other women were surprised and thankful that they did not experience the pain they anticipated. Though Montgomery wrote at length of her fears, after giving birth, she admitted suffering “many more a night with toothache... I have had my baby and none of my forebodings have been fulfilled. I can smile at them now – but they were nonetheless harrowing while they lasted.”<sup>84</sup>

Despite this relief, Montgomery and many other mothers continued to fear their subsequent deliveries. And for those who had had unpleasant birthing experiences, childbirth, understandably, continued to be a cause for anxiety. One American woman remarked in 1871 that she dreaded a second birth “with a dread that every mother must feel in repeating the experience of childbearing.”<sup>85</sup> Similarly, Jennie Curran of Orillia, Ontario made note in 1877 of the worries that surrounded her pregnancy and growing

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<sup>81</sup> Mary Kough Brown Journals, 29 January 1865, HPL.

<sup>82</sup> Diary of Nellie Bailey Bolton, 14 October 1890, Nellie Bolton Fonds, British Columbia Archives. PR-1569. Along with her husband, a physician, Bolton was originally from Athens, Ontario. Dr. and Mrs. Bolton had moved to Port Simpson in 1889, with Dr. Bolton being appointed superintendent of the Port Simpson General Hospital in 1892.

<sup>83</sup> Springett, *For My Children's Children*, pp. 97-98.

<sup>84</sup> *Selected Journals of L.M. Montgomery*, 22 September 1912.

<sup>85</sup> Agnes Just Reid, *Letters of Long Ago* (Caldwell, Idaho: Caxton printers, 1936), p. 25.

family.<sup>86</sup> Lucy Harris, after “recovering” from her first birth, wrote again of her fears of dying while having her second child. In her diary, she recalled taking off her wedding ring due to swollen hands (a common complaint) and commented that she “had an idea perhaps that I might never put it on again.” She also expressed her anxiety at the fact that she had not yet made a will.<sup>87</sup> In her fifth and final pregnancy over a decade later, Harris asserted that she still “felt afraid” when she thought of what awaited her in the birthing room.<sup>88</sup> And despite her explicitly stated relief after her first birth, Montgomery noted while pregnant with a second son two years later, “somehow I look forward to this second birth with more anxiety... perhaps because I realize more clearly how many things might go wrong.”<sup>89</sup>

Women’s persisting, and perhaps, increasing, anxieties went hand in hand with the growing pathologization of both pregnancy and childbirth. Beginning in the second half of the nineteenth century, pregnancy was increasingly cast as a medical “condition” and as a time when so-called “female troubles” could reach new and unprecedented heights.<sup>90</sup> Physicians, who articulated the symptoms leading to the diagnosis of pregnancy, described various treatments for its many associated ailments, and prescribed “parturient balms” to all women “for the purposes of rendering childbirth more easy,”

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<sup>86</sup> Diary of Jennie Curran, January 1877, LAC.

<sup>87</sup> Diary of Lucy Ronalds Harris, 11 May 1870, *The Eldon House Diaries*.

<sup>88</sup> Diary of Lucy Ronalds Harris, 24 March 1880, *The Eldon House Diaries*.

<sup>89</sup> *Selected Journals of L.M. Montgomery*, 24 May 1914, p. 148.

<sup>90</sup> Physicians consistently focused on “female troubles, so disastrous to the happiness of women” in much of the prescriptive literature of the period. Through advice manuals, like Dr. Ira Warren’s 1884 *Household Physician*, women were repeatedly told that they were “subject to a class of distressing complaints peculiar to themselves, involving considerations of a delicate nature.” Melendy, *Ladies Home Companion*, p. 17; and Warren, *Warren’s Household Physician*, p. 339. See also Mitchinson, *The Nature of Their Bodies*, p. 223.

addressed these issues at length in the medical advice literature of the period, and women both contributed to and echoed this language when describing their pregnancies and confinements.<sup>91</sup> In noting that she expected soon “to be laid aside” in the winter of 1879, Jennie Curran wrote that she hoped her “illness” would “be made a blessing.”<sup>92</sup> Throughout her childbearing years, Lucy Harris repeatedly referred to her several pregnancies as her “troubles”, and informed her mother-in-law to expect that she “would be ill” come the month of an anticipated confinement.<sup>93</sup> In 1919, Gwyneth Logan readily admitted her belief that pregnancy “was bound to be a troublesome time... even under the most favourable conditions.” Referring to her state as her “condition”, she quipped, “I certainly am having my full share of symptoms this time.”<sup>94</sup> Regularly listing and describing these “symptoms” for her husband, Logan was careful to repeat a common reassurance that she had recently come across in one of her advice volumes – the “old adage” that “a sick pregnancy is a safe one.”<sup>95</sup>

Echoing and fuelling medical rhetoric that consistently equated “sickness” with the beginning of a labour and confinement, mothers also pathologized the actual birth, recalling and referring to it as an acute period of disease or exceptionally ill health.<sup>96</sup>

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<sup>91</sup> The 1896 *Ladies' Book of Useful Information* that prescribed the balm also asserted that, aside from “troublesome cramps of the legs” and “palpitation of the heart”, “pregnant women are generally affected with heartburn, sickness of a morning, headache, and that troublesome disease, toothache, which accompanies pregnancy.” *The Ladies' Book of Useful Information: Compiled From Many Sources* (London, ON: London Printing and Lithographing Company, 1896), pp. 125-128.

<sup>92</sup> Diary of Jennie Curran, 13 February 1879, LAC.

<sup>93</sup> Diary of Lucy Ronalds Harris, entries 7 May 1868, 21 February 1877, 14 May 1880, *The Eldon House Diaries*.

<sup>94</sup> Gwyneth Logan to Harry Logan, 31 October 1919, 17 November 1919, LAC.

<sup>95</sup> Gwyneth Logan to Harry Logan, 9 October 1919, LAC.

<sup>96</sup> Dr. Pye Henry Chavasse, for example, asserted that “sickness frequently comes on in the beginning of labour and may continue during the whole process... sickness in labour is a rather



Frances Milne noted that she was “very sick all night” when her first child was born.<sup>97</sup> Nellie Bolton wrote that she was “very miserable” on the night of her 1890 confinement and “continued ill until half past three” when “a little daughter was born.”<sup>98</sup> Constance Kerr Sissons of Fort Frances, Ontario, described feeling “very ill” before and during the birth of her first daughter in 1903.<sup>99</sup> Likewise, Eliza Wilson recalled that she was “taken sick” before “a nice strong lassie” was born to her in 1904.<sup>100</sup> This rhetoric persisted throughout the late nineteenth and early twentieth centuries. Mary Coldwell Butcher, who lived near Huntsville, Ontario, described being “taken sick” when she gave birth to her own children in 1895 and 1897. In 1922, she described her daughter’s confinement and the birth of her grandchild using the same language.<sup>101</sup> Historians have suggested that well-to-do women, in particular, were encouraged to openly express their sensitivities and ailments throughout the late-Victorian period. Women’s use of this vocabulary, then, reminiscent of much of the mainstream medical rhetoric of the period, was inseparable from broader social and cultural constructions of fashionable female delicacy and gentility during these transformative years.<sup>102</sup>

Expectant fathers also appear to have perceived pregnancy and birth as periods of sickness, and times when the lives of their wives were potentially at risk. Practicing in

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favourable symptom and... does good.” Chavasse, *Advice to a Wife on the Management of Her Own Health*, pp. 203-204.

<sup>97</sup> Diary of Frances Tweedie Milne, 8 October 1870, AO.

<sup>98</sup> Diary of Nellie Bailey Bolton, 14 October 1890, BC Archives.

<sup>99</sup> Diary of Constance Kerr Sissons, 12 January 1903, edited by Rosalind Kerr, in *The Small Details of Life*, p. 22.

<sup>100</sup> Diary of Eliza Jane Wilson, 30 June 1904, Glenbow.

<sup>101</sup> Diary of Mary Coldwell Butcher, 21 January 1895, 6 April 1897, 1 June 1922. Toronto Reference Library, Special Collections, Baldwin Room.

<sup>102</sup> See Wertz and Wertz, *Lying-In*, pp. 111-113.

rural Manitoba in the early twentieth century, Dr. Wilfred Abram Bigelow recalled a 1907 birth under extenuating circumstances, which he described as “a tedious and difficult case.” As labour progressed, Bigelow “suddenly observed the husband sitting on the kitchen table with a gun.” The husband told the anaesthetist assisting with the delivery, “if my wife dies, the Doc dies too.”<sup>103</sup> The medical practitioners shut and locked the bedroom door, and while the delivery was successful, Bigelow recalled that the anaesthetist, a Dr. Lawther, soon thereafter “did the natural thing and took the shortest and safest way home through the bedroom window.”<sup>104</sup> On his part, Harry Logan echoed his wife’s language about the “troubles and trials” of pregnancy.<sup>105</sup> These accounts suggests that some men, at least, readily recognized parturition as a period characterized by both pain and danger.

Physicians and expectant parents alike expected pain to go hand in hand with the “termination” of the pathologized condition that was pregnancy, and the diarists discussed in this chapter stated that ideas about the relationship between pain and childbirth were “common sense”. Again, Montgomery perhaps put it best:

I have heard much about the agony of the birth chamber. That such agony is the rule rather than the exception generations of suffering women have testified since the dawn of time... All my life I had heard and read of the anguish of childbirth, its risk, its dangers. There were times when I could not believe I would get safely through.<sup>106</sup>

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<sup>103</sup> Abraham Willinsky recalled experiencing similar threats from a patient’s husband during a surgery he performed in the late 1910s. Willinsky, *A Doctor’s Memoirs*, pp. 75-76.

<sup>104</sup> Bigelow, *Forceps, Fin, and Feather*, pp. 56-57.

<sup>105</sup> Harry Logan to Gwyneth Logan, 15 December 1919, LAC.

<sup>106</sup> *Selected Journals of L.M. Montgomery*, 22 September 1912.

## Conclusion

Though the experience of pain is private, individualized, and highly subjective, these shared anxieties had a real impact on parturient women in turn-of-the-century English Canada. As Jacqueline Wolf has pointed out, contemporary studies on birthing pain suggest that women's prior anxieties and expectations of severe pain are factors associated with the most painful labours and deliveries.<sup>107</sup> It is clearly impossible to determine the actual levels of physical pain these "delicate" women experienced in giving birth. Recurring emphases on the common anxieties and fears that surrounded parturition nonetheless demonstrate that for this group of women, the suffering associated with giving birth had a carefully articulated and distinguishable emotional component. These shared anxieties influenced the medical choices of this particular "emotional community," increasingly prompting middle-class women to seek out physicians for the scientific and "modern" comfort they could offer in their interventions, including anaesthesia. Women always managed to retain some agency in this process. Though Wendy Mitchinson has demonstrated that "only rarely in the debate over intervention were the demands of women heard," it is important to keep in mind that obstetrical interventions were not always imposed on women against their will.<sup>108</sup> Women also retained agency in more subtle ways. Nancy Theriot has argued that "women patients were active participants in the process of medicalizing *woman*" as a gender category and

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<sup>107</sup> Wolf, *Deliver Me from Pain*, p. 2.

<sup>108</sup> Mitchinson, *The Nature of their Bodies*, p. 193. Indeed, as Judith Walzer Leavitt has shown, women did not always passively "go along" with this process, but at times, actively agitated for medical interventions including anaesthesia. Leavitt, "Birthing and Anesthesia: The Debate Over Twilight Sleep," pp. 147-164.

identity.<sup>109</sup> In this case, by both conforming to and contributing to existing medical discourses, women were active participants in the process of medicalizing childbirth as well.

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<sup>109</sup> Nancy M. Theriot, "Women's Voices in Nineteenth-Century Medical Discourse: A Step Toward Deconstructing Science," *Signs*, 19:1 (1993), p. 2.

## Chapter 6

### Epilogue: A New Way to Birth? Grantly Dick-Read and The Burgeoning Natural Birth Movement in Postwar Canada

Anticipating a “long-awaited” fourth pregnancy in the spring of 1948, twenty-seven year old Karen Birch<sup>1</sup> from rural Alberta wrote to Dr. Grantly Dick-Read (1890-1959) British obstetrician and the leading figure in the burgeoning Natural Childbirth movement. Praising Dick-Read’s influential volume, *Childbirth Without Fear*, first published in North America in 1944,<sup>2</sup> she asked the doctor “to take on a patient 6,000 miles away,” and requested “a correspondence course in intelligent parturition.”<sup>3</sup> Though Dick-Read responded that Mrs. Birch, was, unfortunately “just outside [his] limit for attending women in labour!” she continued to confer with the doctor for approximately eighteen months.<sup>4</sup> While not his patient, Birch, like other Canadians who wrote to Dick-Read, was an active participant in the broader international campaign for “childbirth without fear,” one of the first movements to contest the increasing medicalization of childbirth that had gone largely unquestioned since the late nineteenth century.

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<sup>1</sup> In accordance with the archival restrictions of the Wellcome Library, all names are pseudonyms. The pseudonyms I have chosen aim to reflect the ethnic and linguistic backgrounds of letter writers.

<sup>2</sup> Grantly Dick-Read, *Childbirth Without Fear: The Principles and Practice of Natural Childbirth* (New York: Harper and Brother Publishers, 1944). See also Paula A. Michaels, *Lamaze: An International History* (Oxford: Oxford University Press, 2014), p. 22.

<sup>3</sup> Karen Birch to Grantly Dick-Read, 5 April 1948. All letters are from Natural Childbirth Correspondence – Mothers – British Commonwealth, 1948-1956 – Canada, Box 45, PP/GDR/D. 90-93, Grantly Dick-Read Collection, Wellcome Library.

<sup>4</sup> Dick-Read went on to joke that, “if I did decide to do so, it is possible that your infant might arrive before your obstetrician.” Grantly Dick-Read to Karen Birch, 1 September 1948.

While historians have examined the impact of Dick-Read's theories in Great Britain and the U.S., his teachings have received little attention in the Canadian context.<sup>5</sup> Additionally, much of the existing literature, including Margarete Sandelowski's seminal work, *Pain, Pleasure and American Childbirth* (1984) has focused on Dick-Read's writings and other popular and medical literature. As a result, the voices of "childbearing women who left few firsthand accounts of their views and experiences" are largely unheard.<sup>6</sup> Mary Thomas's *Postwar Mothers* (1997) began to redress this imbalance, but, like much of the historiography on women's health, focused exclusively on the American and British contexts.<sup>7</sup>

This final chapter provides a starting point to redress these historiographical imbalances by discussing a series of previously unexplored correspondence between Canadians and Dick-Read. Between 1946 and 1956, at least 37 Canadians took the time to write to Grantly Dick-Read. While Natural Childbirth ideologies received some attention throughout the 1930s, as Sandelowski argues, it was not until the North American publication of *Childbirth Without Fear* in 1944 that the method entered the mainstream of popular medical discourses in the United States, effectively attracting

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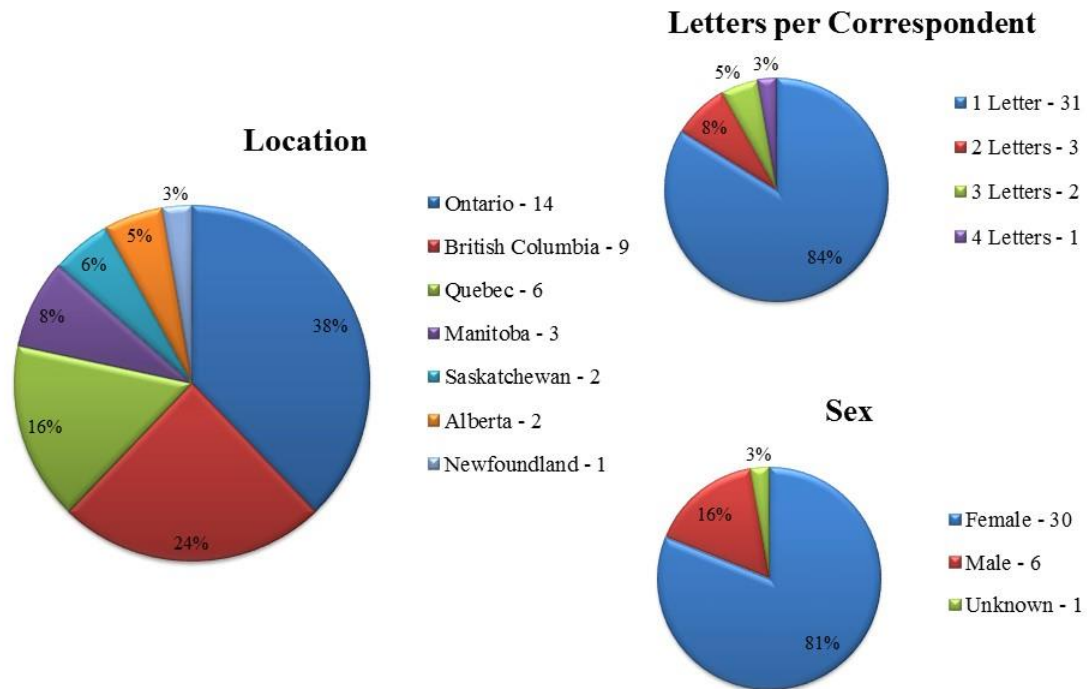
<sup>5</sup> The Canadian medical profession's responses to Natural Childbirth are briefly examined in Wendy Mitchinson's *Giving Birth in Canada* (2002), and Dick-Read's role in the development of the natural childbirth movement in the 1960s and 1970s is briefly addressed in Canadian histories of breastfeeding and caesarean section. See Mitchinson, *Giving Birth in Canada*, pp. 215-216, Tasnim Nathoo and Aleck Ostry, *The One Best Way?: Breastfeeding History, Politics and Policy in Canada* (Waterloo: Wilfrid Laurier University Press, 2009) and Sally Elizabeth Mennill, "Prepping the Cut: Caesarean Section Scenarios in English Canada, 1945-1970", PhD diss., University of British Columbia, 2012.

<sup>6</sup> Sandelowski, *Pain, Pleasure, and American Childbirth*, p. 139.

<sup>7</sup> Mary Thomas, *Post-War Mothers: Childbirth Letters to Grantly Dick-Read, 1946-1956* (Rochester, University of Rochester Press, 1997).

Figure 6.1

## Grantly Dick-Read's Canadian Correspondents



expectant mothers there, and in Canada as well.<sup>8</sup> As demonstrated in Figure 6.1, Dick-Read's Canadian correspondents were located across the country, with the largest number in Ontario, followed by British Columbia, and Quebec. This suggests that natural childbirth theories had the power to cross Canadian cultural divides, a point also made by individual correspondents.<sup>9</sup> The majority of correspondents were female, although six

<sup>8</sup> Sandelowski argues that 1948, the year after Dick-Read's first American lecture tour, was a key turning point in this regard: "relatively few Americans – except those who had read one of Read's British books or papers, DeLee's 1938 textbook, or De Kruif's 1936 series in the *Ladies Home Journal* – knew of the Read method before Harpers published *Childbirth Without Fear* in 1944. It was not until 1948 that enough Americans knew of Natural Childbirth to make it an important part of American life." Sandelowski, *Pain, Pleasure, and American Childbirth*, p. 89.

<sup>9</sup> Lorraine Blair, for example, told Dick-Read that his work had value for all Canadians, writing, "Your book was very inspiring even for a young girl and although a French speaking Canadian, I

men also took the time to write to Dick-Read. While it is more difficult to infer the class and racial or ethnic backgrounds of letter writers, the majority of correspondents appear to have been well educated, hailing from the middle or upper middle classes. British backgrounds appear to predominate. It is clear, then, that by and large, letter writers came from a select group of women who would have been exposed to Dick-Read's name and ideas. Most appear to have written on one occasion only, though a few did carry on correspondences with the doctor. For all letter writers, however, the "atmosphere of anonymity created by correspondence" appears to have encouraged the frank expression of intimate details concerning childbirth experiences.<sup>10</sup> What emerges from a close reading of these materials suggests, in some ways, a counterpoint to earlier and ongoing emphases on the pathologization and medicalization of birth in late nineteenth and early twentieth century English Canada. Ultimately, however, Dick-Read's vision of "Childbirth without Fear" retained much of the conservatism of earlier periods.

In the postwar years, Canadians wrote to Dick-Read praising his crusade and expressing a desire to further promote the Natural Childbirth movement in Canada. Letter writers sought referrals to physicians amenable to the principles of natural childbirth, as well as more generalized marriage and family advice. At the same time, in their engagement with this international movement, Dick-Read's correspondents provided their own critical commentary on the Canadian medical establishment. More broadly, they used their letters to express their views on the nature of the female body, pain, and giving birth. Although the movement marked a turning point in the history of childbirth

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did not have any difficulty in reading it." Lorraine Blair to Grantly Dick-Read, 28 November 1950.

<sup>10</sup> Thomas, *Postwar Mothers: Childbirth Letters to Grantly Dick-Read*, p. 19.



and, in many ways, the end of the first heyday of obstetrical anaesthesia, both Dick-Read and his correspondents continued to articulate traditional interpretations of these subjects.

### Natural Birth, Dick-Read, and *Childbirth Without Fear*

By the interwar period, anaesthetized birth – or, at the very least, the provision of some analgesia or pain relief during delivery for the majority of urban, “white,” middle-to-upper class parturient patients during delivery – was increasingly commonplace throughout much of the western world. Groups such as the National Birthday Trust Fund (NBTF), a British organization that aimed to make both childbirth and motherhood safer by advocating increased access to anaesthetics for all women, regardless of class, gradually extended their efforts to the international stage, including Canada. Following a pilot effort in the UK in the early 1930s, in December 1932 the NBTF sent a supply of chloroform capsules overseas to Dr. J.L. Biggar, National Commissioner of the Canadian Red Cross Society. These were to be used in the Red Cross Outpost Hospitals that served many rural and isolated communities across the nation, where women often gave birth without physician assistance.<sup>11</sup> These efforts, based on the growing assumption that all women required at least some analgesic or anaesthetic pain relief during birth, were appreciated by both Biggar and Helen MacMurchy, Chief of the Division of Child Welfare. The former reported to the NBTF that the capsules received “unanimously

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<sup>11</sup> In these rural and isolated outposts, the majority of deliveries were conducted by nurses. For more information see Jayne Elliott, “A Negotiated Process: Outpost Nursing Under the Red Cross in Ontario, 1922-1984,” in *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada*, ed. Myra Rutherdale (Montreal and Kingston: McGill-Queen’s University Press, 2010), pp. 245-277.

favourable” reviews, with their use “having been appreciated by the patients and having formed an effective adjuvant in the equipment of our [Canadian] nurses.” MacMurchy, in particular, assured the NBTF that the capsules were in use at all outpost hospitals “with the exception of a few where a doctor is directly in charge,” and added that “further steps would be taken to secure an additional supply.”<sup>12</sup> Along with the growing provision of anaesthesia to laboring women by physicians across the country, NBTF efforts demonstrate that this particular aspect of the medicalization of birth had reached unprecedented levels by the interwar period.

At the same time, however, the beginnings of natural childbirth movements represented some of the first significant and organized opposition to this medicalization. One of the key figures in the early natural birth movement was the British obstetrician Grantly Dick-Read, who popularized the term in his titular work, *Natural Childbirth*, published in the UK in 1933. His “new” approach – strikingly reminiscent of many of the themes discussed in Engelmann’s *Labor Among Primitive Peoples*, published a half century earlier – was based on his early twentieth century observations of the births of working-class women and those who represented racial “others.” In particular, the deliveries of a Whitechapel woman in the first decade of the 1900s, and a Belgian “peasant woman” he saw deliver a child in a field during the First World War, stand out in his memoirs, along with “evidence” of other so-called “primitive” births he would later collect during a mid-century trip to Africa. Based on a near half century of participation and observation in childbirth, Dick-Read concluded that fear of giving birth caused

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<sup>12</sup> Letter from J.L. Biggar and Helen MacMurchy to NBTF, December 1932, “Analgesia – Chloroform Capsules – Reports and Articles on the Use of Chloroform Capsules, June 1932 to November 1934,” SA/NBT/H.1/5, National Birthday Trust Fund Collection, Wellcome Library.

tension, and that this tension contributed to heightened contractility and spasms in the cervix, resulting in pain.<sup>13</sup> While this attention to the psychological aspects of childbirth was by no means new,<sup>14</sup> Dick-Read argued, above all else, for the need to overcome this fear, which he saw as a major obstacle to women's healthy fulfillment of the maternal instinct.<sup>15</sup> To this end, prenatal education, and a close relationship between the expectant mother and her physician, were the keys to overcoming pain in childbirth.

Dick-Read envisioned the ideal birth as one involving a conscious, confident, and active participant, rather than a drugged patient.<sup>16</sup> Since growing numbers of middle-class women throughout the western world were increasingly accustomed to receiving pharmacological pain relief in the process of giving birth, historians have suggested that Dick-Read's vision of a drug free birth "bucked the trend" in North American and British obstetric practice.<sup>17</sup> Nevertheless, his ideas found a captive audience during the first years of the "baby boom" that followed the Second World War, as Canadian women tended to marry at a younger age, have their first child earlier and bear greater numbers of children more closely spaced together than their counterparts a generation earlier – a new reality

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<sup>13</sup> Grantly Dick-Read, *Autobiography* – Unpublished Manuscript, PP/GDR/A.92, Instalment Two, pp. 22-24; Instalment Three, p. 7, Grantly Dick-Read Collection, Wellcome Library. Dick-Read's fixation on so-called "primitive" births was by no means new. See Chapter 2 for a discussion of Engelmann's *Labor Among Primitive Peoples* (1882), along with other examples.

<sup>14</sup> In the early twentieth century, J. Clifton Edgar had argued that "suggestion and hypnotism" has some value in childbirth, but "only in the very early stages." "Painless Labor," *CL* (1917), p. 218.

<sup>15</sup> Dick-Read was less concerned about the impacts this fear had on women's own physical and mental health, a fact that undergirds his traditional understandings of women's role, in both the family and society, despite what some perceived to be the "radical" nature of the approach he promoted.

<sup>16</sup> Lecture on "Pains of Labour", delivered at Norwich, 17 October 1933, Lectures, 1933-1948, PP/GDR/C.71, Grantly Dick-Read Collection, Wellcome Library.

<sup>17</sup> Paula A. Michaels, "Pain and Blame: Psychological Approaches to Obstetric Pain, 1950-1980," in *Knowledge and Pain*, eds. Esther Cohen, Leona Toker, Manuela Consonni, and Othiel Dror, (Amsterdam: Rodopi, 2012), p. 233.

that, understandably, led many mothers to want to have more of a say regarding the events taking place in the birthing room.<sup>18</sup> These theories appealed to a growing group of expectant parents, at a time when medical experts continued to enjoy unprecedented levels of authority and success in advising the lay public on a variety of health matters, including maternity.<sup>19</sup>

As would be expected, those motivated to write letters tended to respond very favourably to Dick-Read's message. Karen Birch wrote that both she and her younger sister were "immediately pleased" with Dick-Read's "damn good sense," and went so far as to state her intent to name her next son in honor of the doctor.<sup>20</sup> Writing from Montreal in the summer of 1950, Edith Zimmerman praised Dick-Read's work as "a valuable contribution toward mankind" and "a new wonderful God-send to women."<sup>21</sup> Praise came from men and women alike. Ralph Brown, of Saskatoon, wrote to Dick-Read in early 1951 to say that he had enjoyed the doctor's *Childbirth Without Fear*; Maurice Dupont,

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<sup>18</sup> Demographic studies suggest that for younger groups of married women (those under age 30), birth rates continued to climb until 1956. *Canadian Women: A History*, Second Edition, eds. Allison Prentice et al, (Toronto: Thompson Nelson, 1996), p. 379.

<sup>19</sup> Roy Porter argued that "the success of medical pundits in talking directly to the public on key health matters – sometimes over the heads of their professional peers, and contravening conventional social, moral, and even medical wisdom" was a twentieth century phenomenon. As discussed in earlier chapters, the messages contained in medical advice, with the aim of safeguarding the health of Canadian mothers and children, were framed as all the more significant in interwar period. Additionally, Porter suggested that "childbirth has been one classic arena" in which this type of communication took place: "though birth was slowly becoming safer, a succession of dissenting voices was raised, protesting against the authorized medical rituals." Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: Norton, 1997), p. 696.

<sup>20</sup> Karen Birch to Grantly Dick-Read, 12 October 1948. After giving birth, she wrote again to the doctor and confirmed: "Natural Childbirth" is the ecstatic experience you promised in your book, and I can never thank you enough for writing that wonderfully inspiring volume." Birch to Dick-Read, 24 May 1949.

<sup>21</sup> Edith Zimmerman to Grantly Dick-Read, 17 July 1950.

of Cobourg, Ontario, wrote in 1953 to thank Dick-Read “for having written that splendid book on Natural Childbirth.”<sup>22</sup>

Enthusiastic about the possibilities of the method but unsure of where to turn, letter writers asked Dick-Read for referrals to physicians who could assist them in “achieving” natural births.<sup>23</sup> In 1947, Mrs. George Spark of Ottawa described difficulty finding information on the method in postwar Canada, writing that though she had tried to obtain Dick-Read’s “A Revelation of Childbirth” and “other literature on the subject,” she was, as of yet, unsuccessful. As Spark’s first child was due in March, she wrote that she was “very anxious” to have Dick-Read’s reply “at the earliest possible moment.”<sup>24</sup> Writing in the same year, Hilda Garner, of Victoria, described a first stillbirth and inquired if the doctor knew of any supporters of Natural Childbirth in her area, as she hoped to have more support in the delivery room beyond practicing the exercises as specified in his book and was “prepared to take any amount of time and trouble.” Dick-Read responded that Garner would “be surprised” if she knew of “the number of letters [he] receive[d] from British Columbia,” and though he referred her to both a nurse in Vancouver and a Dr. Duncan of Duncan, BC, commented that he had “a great urge to

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<sup>22</sup> Dupont also expressed these wishes on behalf of his wife. Maurice Dupont to Grantly Dick-Read, 15 April 1953.

<sup>23</sup> Historians have pointed out that Dick-Read’s emphasis on “achieving” a natural birth could have negative effects in terms of how parturient women conceptualized their deliveries. Cheryl Krasnick Warsh, for example, argues that because of Dick-Read’s “cult-like” following, “when women who faithfully followed the methods experienced intense labour pains and required anaesthetics or caesarean sections, they sometimes felt like personal failures.” Warsh, *Prescribed Norms*, p. 148. With the resurgence of the “new midwifery” in Canada in the past two decades, this continues to be a cause for concern, leading many midwives to call for “a flexible rather than fixed construction of natural birth.” See Margaret Macdonald, “Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada,” *Medical Anthropology Quarterly* 20, no. 2 (June 2006), pp. 235-356.

<sup>24</sup> Mrs. George Spark to Grantly Dick-Read, 5 January 1947.

come to British Columbia myself.”<sup>25</sup> Writing from Saskatoon in 1953 the month before a cross-country move, Joan Brooks asked Dick-Read if he could refer her to a new physician in Toronto. She enclosed £1 with her inquiry, which she noted, was the going fee for an office visit to a Canadian physician, writing, “I would like to think of you as my doctor.” Dick-Read directed Brooks, as he did many other correspondents, to write to Miss Miles of the Toronto branch of the Canadian Mothercraft Association, established in 1931 based on principles laid out by New Zealand’s Dr. Truby King.<sup>26</sup> Such advice may have been problematic for some Canadian mothers – particularly those living in and attending other provincially-run prenatal and baby clinics in the Toronto area – given the tensions between local physicians, including leading Canadian pediatrician Alan Brown, and Mothercraft nurses trained in “foreign methods” that had been ongoing since the Association’s establishment in the early 1930s.<sup>27</sup>

For women who had recently moved to Canada as part of the postwar immigration boom – like their counterparts of previous generations, as discussed in Chapter 5 – such referrals were especially helpful. Joy Rames, who emigrated from

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<sup>25</sup> Hilda Garner to Grantly Dick-Read, 26 September 1947, and from Grantly Dick-Read to Hilda Garner, 5 October 1947. In 1950, Edith Zimmerman asked for a similar referral to a physician in the Montreal area. Edith Zimmerman to Grantly Dick-Read, 17 July 1950.

<sup>26</sup> Brooks also asked Dick-Read for advice on where she might be able to purchase a special maternity brassiere along the lines of one he described in his book. In response, Dick-Read remarked that he was most “impressed by [Mrs. Brooks’] thoughtfulness, which must be part of your nature, in sending me £1. I write many hundreds of letters to those whom I hope to help with my advice or information, but acts equivalent to yours are very rare.” Joan Brooks to Grantly Dick-Read, 21 April 1953, and Dick-Read to Brooks, 27 May 1953. See also Norma J. McDiarmid, *The Canadian Mothercraft Society: An Embodiment of Practical Idealism and Philanthropy* (St. Catharines: Lincoln Graphics, Inc., 1994), p. 35.

<sup>27</sup> Cynthia Comacchio has argued that the “Mothercraft controversy” was essentially a struggle for control between Canadian physicians and Mothercraft nurses, with the former taking issue with nurses’ role “in prescribing for their infant patients, a role that held serious portents for physicians involved in child welfare.” Comacchio, *Nations Are Built of Babies*, pp. 150-152.

England the month before writing to Dick-Read in 1950, described herself and her husband as “very much ‘strangers in a strange land’” and asked for the doctor’s help in securing a physician. Rames recognized the difficulties that could arise should she give birth “under the care of a doctor who was antagonistic to the theory.”<sup>28</sup> Writing from her new home in Northern Ontario, Rames was advised to write to a doctor in Windsor, nearly ten hours away.<sup>29</sup> Likewise, Arlene Scott of Hamilton who had arrived from London in the mid-1940s asked Dick-Read for advice on finding a Natural Childbirth practitioner in a 1949 letter.<sup>30</sup> Reflecting the growing involvement of many fathers in the birth experience, men also sought referrals for their wives, as was the case when Toronto’s Samuel Mockford, who had emigrated from England in 1946, wrote to Dick-Read in December 1949 in anticipation of his wife’s first baby the following summer.<sup>31</sup> Aware of the difficulties of finding a suitable physician, especially one versed in and supportive of Natural Childbirth, women also took it upon themselves to offer recommendations. In 1951, Hattie Jones of Toronto told Dick-Read that she did not hesitate in recommending two female doctors.<sup>32</sup> Likewise, Katherine Passman of Windsor wrote that she had learned from her nurses of other women interested in Natural

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<sup>28</sup> Joy Rames to Grantly Dick-Read, 8 March 1950.

<sup>29</sup> Grantly Dick-Read to Joy Rames, 28 March 1950. Dick-Read regularly recommended a select number of colleagues to his Canadian correspondents, so it is unclear whether or not he knew of the geographic obstacle such a referral would have presented for Rames.

<sup>30</sup> Scott asked for advice as to how she should “go about solving the problem of medical aid sympathetic to [the Natural Childbirth] viewpoint.” As with many other correspondents, Dick-Read instructed her to get in touch with the Toronto branch of the Canadian Mothercraft Association. Arlene Scott to Grantly Dick-Read, 6 July 1949, and Dick-Read to Scott, 1 August 1949.

<sup>31</sup> Samuel Mockford to Grantly Dick-Read, 27 December 1949. See also Walzer Leavitt, *Make Room for Daddy*.

<sup>32</sup> Although she did not explicitly suggest that their youth made them more amenable to the principles of Natural Childbirth, she did note that both physicians were “very young, they only graduated in the last two or three years, but both have been highly recommended by other medical people.” Hattie Jones to Grantly Dick-Read, 12 January 1951.

Childbirth in her area, and recommended “two doctors in the near vicinity” who were “trying [Dick-Read’s] way and meeting with much success.”<sup>33</sup>

### Commenting on Doctors and Deliveries

Caught between wartime images that glorified women’s participation in the workforce and postwar representations that cast the ideal Canadian woman as a stay at home wife and mother, female letter writers saw their correspondence with Dick-Read as an opportunity to seek the doctor’s advice on a variety of issues.<sup>34</sup> Perhaps not surprisingly, given the fact that the average age at first marriage continued to decline throughout this period, some correspondents asked Dick-Read for marital advice, particularly as it related to the impacts of childbearing. Ruth Finlay of Toronto, for example, wrote to the doctor in 1955, commenting on a section of his book in which he described how a negative birthing experience could lead to marital difficulties. Expressing anxiety over her lack of sexual desire in the seven months since she had delivered her son, Finlay lamented that this problem was ruining her marriage, stated that she had no one else to turn to, and asked for advice.<sup>35</sup> Dick-Read responded that he was “very grieved” to hear of Finlay’s difficulties, and commented that “some cases do need a

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<sup>33</sup> Katherine Passman to Grantly Dick Read, 11 May 1951, and Dick-Read to Passman, 3 July 1951.

<sup>34</sup> Despite widely held ideas about the 1950s as a “domestic” decade, in many ways, Canadian women enjoyed greater freedoms in the postwar period, for example, in entering Canadian universities and the labour force at steadily increasing rates from the 1950s onwards. *Canadian Women: A History*, pp. 338, 380, 397.

<sup>35</sup> Finlay wrote “Dr. Read – this has happened to me and it is ruining our marriage. My question is what can I do to stop this happening? I’m so mixed up and in such a turmoil I don’t know what to do or who to turn too [sic].” Ruth Finlay to Grantly Dick-Read, 21 February 1955.



little extra care, instruction, and help.” He assured her that he would make inquiries, and advised her “don’t lose hope, because it does come right in time...”<sup>36</sup>

While such inquiries speak to the growing authority of the physician as “expert” on a variety of subjects, these letters also offer a valuable window into the Canadian medical landscape during this period. Letter writers contributed to existing ideas about the nature of the female body, pain, and giving birth, echoing, fuelling, and at times, challenging the standard medical rhetoric on these matters. Supporters of Natural Childbirth argued that women’s long-standing ignorance of the reproductive process – a point highlighted in much of the professional medical literature produced in the late nineteenth and early twentieth centuries – was a major problem and the root cause of tension and pain. In her second letter to Dick-Read, Karen Birch agreed with this idea, stated that her upbringing was typical of “the mis-education that most middle-class girls receive” on “the so-called facts of life,” and commented that this lack of information was likely due to her mother’s ongoing efforts to keep Birch and her sister “pure.” Birch remembered a lone speech from her mother as follows: “When you get married the man sleeps in your bed, and sticks his thing in you and you get a baby. Don’t ever let a man kiss you before you’re married, or you’ll get a baby and be disgraced and Pa’ll kick you out.” She summed up her reaction with a very Canadian statement: “Lovely start to adolescence eh!” Recognizing that such “lessons” were a product of her mother’s own upbringing, Birch was forced to look to other sources for information on reproductive health and sexuality, and as a result, commented that she found the first month of her

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<sup>36</sup>Grantly Dick-Read to Ruth Finlay, 21 March 1955.

marriage at age 21 “very disappointing.”<sup>37</sup> While Birch’s account demonstrates that concerns about “respectability” did shape the sexual education of young women well into the early twentieth century, there were exceptions to this trend. Lorraine Blair of Montreal, for example, commented that her mother, a nurse, had relayed “almost all the information concerning the... reproduction system,” but still emphasized the informative nature of Dick-Read’s work in “lifting the last curtain” of uncertainty with regards to childbearing.<sup>38</sup>

Letter writers also tended to echo widely held beliefs about the relationship between pain, civilization, and childbirth. Just as Dick-Read had highlighted the painfree labours of working class, “primitive,” and “peasant” women throughout his work, Karen Birch recounted her own examples that were markedly in line with medical perceptions of the relationship between class, race, and sensitivity to labour pain. First, Birch described the case of a “Cree Indian woman” who was in the next bed when she delivered her first son in 1943 and laboured in silence for over fifteen hours. She stated that the general conclusion from the “modern young mothers” in the ward was “that she was just a dumb Indian and didn’t know any better!” Second, she recalled a “Ukrainian woman” who, during Birch’s second confinement “just walked into the caseroom, hung up her coat, took off her pants, lay on the table and had her baby.” Her final, very “Canadian,” example of the relationship between civilization and sensitivity (or perceived lack thereof) was the case of her neighbour, “a big, blonde Swede [whose] reading consists of

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<sup>37</sup> Birch sought out books including the Norwegian *Kristin Lavransdatter* trilogy and *Gone with the Wind*, and found her work as a maid on a Maternity Ward beginning at age 17 to be very informative. Karen Birch to Grantly Dick-Read, 12 October 1948.

<sup>38</sup> Lorraine Blair to Grantly Dick-Read, 28 November 1950.

the mail-order catalog” who “had her baby all by herself on a day when the temperature was [minus] 57°C.” Birch summed up her observations as follows:

An unlettered primitive, a semi-civilized peasant, and an uneducated farm girl – all have had their babies easily and sweetly. While I, who worked my way thru [sic] University, went thru [sic] the agonies of the damned...I can’t retrogress thousands of years to revert to a state of primitivism, peasantry, or bovine stupidity.

Considering the problem of painful birth, she concluded, as Dick-Read did, that “presumably the answer...is re-education.”<sup>39</sup> Male letter writers also echoed these ideas about the relationship between civilization and sensitivity. Maurice Dupont, for example, wrote that he had “travelled in native cultures and was predisposed to accept [Dick-Read’s] ideas by reason of [his] own observations of the facility with which more primitive peoples deal with this problem [childbirth].”<sup>40</sup> These accounts suggest that older perceptions of the relationship between civilization and sensitivity, along with the notion that modern life had made birth an exceedingly painful experience, remained widely accepted into the mid-twentieth century.

Many of those who took the time to write to Dick-Read used their letters as an opportunity to voice their criticisms of the nature of medicalized birth in Canada to what they recognized as a receptive and sympathetic audience. Letter writers regularly criticized the interventionist treatment that women endured at the hands of medical professionals. Birch described painful enemas and other “preparatory” procedures, as well as harsh treatment from nurses, including one who, during her first birth, slapped her

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<sup>39</sup> Karen Birch to Grantly Dick-Read, 12 October 1948.

<sup>40</sup> Maurice Dupont to Grantly Dick-Read, 15 April 1953.

in the face and told her, “Oh for Christ sake, shut up your damned howling.” She told Dick-Read that “the slapping and abuse” were repeated during her second delivery.<sup>41</sup> Hattie Jones suggested to Dick-Read that the trend in most Canadian hospitals was “to treat any woman in labour as a mental patient,” and noted that the expectant patient “is humored, but nothing she says is listened to.” Like Birch, Jones also voiced criticism of the obstetrical nurses she encountered, noting that though her doctor had said that they were “often not up to standard,” she “found that out the hard way.”<sup>42</sup> Geraldine Stowe of Edmonton recalled in her 1953 letter that at the time of her first confinement in 1947, she was “absolutely appalled at the way I and other expectant mothers were treated.”<sup>43</sup> Other criticisms of “modern” obstetric practice were expressed by Betty Daniels of Toronto who wrote that it was “a pity” that hospitals failed to “make provision for rooming in the baby with the mother,”<sup>44</sup> and Laurel Rice who reported to Dick-Read that the city’s hospitals were “crowded and the nursing staff pitifully overworked.” Lamenting that Canadian nurses were trained to “expect pain” during birth, Rice suggested that the poor conditions and treatment women received giving birth in Toronto’s hospitals were “social and economic in nature.” In the face of these seemingly endemic problems, she wondered: “how can women best help themselves in the face of the antiquated routine of the average hospital?”<sup>45</sup>

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<sup>41</sup> Birch also recounted the negative experiences of her friend, “Helen”, during her first delivery in 1940 or 1941. Describing Helen as “a highly nervous emotional girl,” Birch commented that “she had a boy seven years ago and was brutally mistreated. She was crying when she came out of the gas, and would not look at her baby. She has lived in fear of pregnancy ever since...”

Karen Birch to Grantly Dick-Read, 12 October 1948.

<sup>42</sup> Hattie Jones to Grantly Dick-Read, 12 January 1951.

<sup>43</sup> Geraldine Stowe to Grantly Dick-Read, 5 March 1953.

<sup>44</sup> Betty Daniels to Grantly Dick-Read, 13 December 1955.

<sup>45</sup> Laurel Rice to Grantly Dick-Read, 24 May 1955.

In singling out nurses for criticism, letter writers offered an implicit comment on the obstetric nurse's unique and changing position in the doctor-patient power relationship. In the mid-twentieth century, the obstetric nurse filled an intermediate role in the birthing room, sometimes charged with delaying delivery until the physician arrived for "climactic moment" and effectively justified his (or her) role in the birth.<sup>46</sup> These nurse-physician tensions when it came to controlling births had older roots. Peikoff, for example, described the nurse supervisor of the obstetric ward at Edmonton's Royal Alexandra Hospital in the 1920s as "always the hero" for frequently, and controversially, conducting deliveries while waiting for the doctor to arrive.<sup>47</sup> By mid-century, Canadian women saw the natural childbirth movement as an arena where they could voice their criticism of this aspect of the medical system.

Letter writers told Dick-Read that they were anaesthetized against their will to prevent an untimely delivery beyond the physician's control, – a practice that had much older origins<sup>48</sup> – and wrote that they "felt cheated" out of a Natural Birth as a result. These criticisms went alongside broader medical critiques about the overuse of anaesthetics that had been growing since the interwar period,<sup>49</sup> as well as women's comments that suggested that "the common practice" in many Canadian hospitals seemed

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<sup>46</sup> Sandelowski, *Pain, Pleasure, and American Childbirth*, p. 64.

<sup>47</sup> Peikoff, *Yesterday's Doctor*, p. 3.

<sup>48</sup> As a medical student at the University of Western Ontario in 1900, J.M. Smith was taught that if the expectant patient failed to "obey" the physician's instructions "not to bear down" before the appointed time of delivery, anaesthesia could be freely given, with the head delivered between the pains. J.M. Smith, Lecture Notes on Obstetrics (as taken from Dr. Meek or Dr. Eccles), University of Western Ontario, 1900, A00-194-01, Archives Research and Collections Centre, Western University.

<sup>49</sup> A 1934 piece in the *CPHJ* suggested that "the insistent demand for a lessening of the pain and discomfort of childbearing" contributed to high rates of both unnecessary interference and maternal mortality. J.T. Phair, "Why Maternal Deaths?" *CPHJ* 25, no. 3 (March 1934), p. 142.

to be “to clamp an anaesthetic mask on your face whether you want it or not.”<sup>50</sup> After giving birth in 1940s Winnipeg, Elizabeth Walker wrote to Dick-Read describing her experience. Though her anaesthetist was a friend and colleague of her husband, and Walker repeatedly expressed her wishes for a natural birth, she recalled that “in the end they told me the baby was arriving too fast and the doctor hadn’t arrived and they just put the mask over my face and that was that... looking back I feel I was cheated out of the most wonderful few hours of a woman’s life.”<sup>51</sup> Hattie Jones also recalled a particularly negative experience. Labouring quietly according to Dick-Read’s teachings, Jones told her nurses that she believed she had entered the second stage and advised them to call her doctor. She remembered:

No one listened. After twenty minutes the head nurse came in for a routine check and when she took one look I was whipped into the delivery room with the speed of light. It took my doctor ten minutes to get there, but the nurses were afraid the baby would be born first. So what did they do! They straightened my legs and SAT on them. If I have very known agony and been insane with pain those next ten minutes was [sic] it.

Jones saw this mistreatment as having physically damaging effects, resulting in a perineal tear. She insightfully explained the Canadian context to Dick-Read – “Because there are no midwives here it is thought to be a crime of the worst sort to allow a baby to be born

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<sup>50</sup> Edith Zimmerman to Grantly Dick-Read, 17 July 1950. In contrast to Zimmerman’s comments, Lorraine Blair recalled that her mother “had two children at a hospital without anaesthetics at a time when doctors administered it as routine.” Lorraine Blair to Grantly Dick-Read, 28 November 1950.

<sup>51</sup> Elizabeth Walker to Grantly Dick-Read, 19 December 1946.

without a doctor” – and pointed out that friends had endured or witnessed similar experiences.<sup>52</sup>

Laurel Rice described an equally horrific experience during the birth of her second child in 1955. Being wheeled to the delivery room, Rice remembered:

The nurse wheeling the stretcher pushed my knees together and told me not to push! (She might as well have asked me to stop my heart beating). When we entered the delivery room, I bore down a second time, and was again told to keep my knees down. I replied that I could not stop, and was told to...not be stupid. By the flurry and panic of the nurses I realized that the doctor had not been called and the staff was fearful lest I should deliver before he arrived. All the efforts of the staff seemed to be concentrated on forcing my unwilling knees down and preventing me from pushing.

Despite this force, Rice recalled that labour progressed and the baby was about to be born, until she was “put right under” by anaesthetist as a means of slowing labour and delaying the moment of delivery. She awoke a half hour later to the doctor presenting her with her baby.<sup>53</sup>

Exercising her agency as a patient, Rice took it upon herself to express her dissatisfaction to the attending physician who, in her words, had “unceremoniously bounced” her from “the scene in which [she] should have had ‘star billing’.” She

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<sup>52</sup> Jones recalled that “A girlfriend of mine had her legs crossed and held for eight hours – a friend who is a nurse has told me that many a time she has covered her hand with sterile gauze and held in the head until the doctor arrived. How anyone could be so cruel is beyond my comprehension.” Hattie Jones to Grantly Dick-Read, 12 January 1951.

<sup>53</sup> Laurel Rice to Dick-Read, 24 May 1955.

included a copy of this correspondence in her letter to Dick-Read. Writing to an anonymized “O.M.,” Rice chastised the doctor:

Your administration of an anaesthetic at a moment when it was neither needed nor wanted ended my hopes for enjoying to the fullest an experience which I had every right to expect – conscious cooperation in the birth of my child. I am fully aware that anaesthetic was administered to retard delivery until the doctor should arrive – but I cannot excuse its use for that reason. As the only doctor present at the time, it was your duty to assist and aid a perfectly natural function and not interfere with it.<sup>54</sup>

While some women, a half-century earlier, may have clamoured for anaesthesia and pain relief – including, most notably, those vocal proponents of Twilight Sleep in the early 1910s – women such as Rice exercised their agency as patients in a diametrically opposed but equally significant way. They argued for the right to remain conscious and aware during delivery.

### Spreading the Gospel of Natural Birth

Those who took the time to write to Dick-Read played a key role in the movement’s growth. Both male and female letter writers consistently mentioned their efforts to “spread the Natural Childbirth gospel” to friends, relatives, doctors, and nurses, and were pleased to report any signs the movement was gaining momentum. After buying Dick-Read’s *Childbirth Without Fear* in 1947, Birch reported that she lent her volume to

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<sup>54</sup> Laurel Rice to Dr. O.M., 9 June 1955.



her younger sister and two friends over the course of the following year.<sup>55</sup> In a 1949 letter, Birch related her observations that “CWF” (Childbirth without Fear) was “becoming a ‘movement’ in the USA,” and assured Dick-Read, “if my missionary fervor can accomplish it, said movement will start in Alberta, also.”<sup>56</sup> Over the coming months, she lent the “little book” to “a young pediatrician-to-be” – her husband’s cousin – and commented that her husband, friends, and relations were “preaching CWF ‘til it’s a wonder we’re not forcibly shut up.”<sup>57</sup> Birch’s “missionary fervor” aside, Arlene Scott, writing from Southern Ontario in the same year, offered a different perspective on the spread of the movement, commenting that the method “was certainly not applied in a number of recent maternity cases I know recently.”<sup>58</sup> Nevertheless, women wrote of their continued efforts to promote natural birth.

Writing from Toronto in 1951, Hazel Carter reported to Dick-Read, “your cause is spreading more rapidly than you might dream...you can’t get your book in any of the stores...because their [sic] all sold out” and assured the doctor that she and her “few recruits” would continue to “spread the word” on Childbirth without Fear.<sup>59</sup> After moving to Edmonton and having a successful natural birth in the summer of the same year, Joy Rames told Dick-Read that as a result of her experience “they now have the nurses in the Labour rooms of the University Hospital giving instruction in relaxation.” She also

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<sup>55</sup> Karen Birch to Grantly Dick-Read, 12 October 1948.

<sup>56</sup> Karen Birch to Grantly Dick-Read, 24 May 1949.

<sup>57</sup> Karen Birch to Grantly Dick-Read, 30 August 1949. In the same letter, Birch told Dick-Read “My husband paid you a tribute which I must pass on to you. It is the more unusual in that Fred is reserved and reticent even for the quiet Canadian he is, our race not being given to high flowery speeches much. I remarked that you were probably one of the greatest men living, at least the most influential. Fred said, ‘Dr. Read is the greatest man since Jesus Christ.’”

<sup>58</sup> Arlene Scott to Grantly Dick-Read, 6 July 1949.

<sup>59</sup> Hazel Carter to Grantly Dick-Read, 8 June 1951.

commented that after giving birth, “several of the doctors came to ask me about it [the method] so maybe they will take it up.”<sup>60</sup> Katherine Passman suggested that Dick-Read “would be glad to know” that his work was “advancing”, and noted her plans to give a copy of *Childbirth Without Fear* to her obstetrician. Dick-Read responded to Passman with an offer to send reprints of his work to the doctors she had mentioned, writing that such a gesture would “tremendously augment” Passman’s “kindly efforts to help mothers, and to extend this approach to childbirth...for in reality it is the Doctors who can do so much for the women of our time.”<sup>61</sup> By reminding Passman of the significance of the physician’s role, Dick-Read upheld professional-lay power dynamics.

Throughout the 1950s, Dick-Read’s correspondents continued to highlight their efforts, telling the doctor of how they recommended and lent their copies of his work to everyone they could,<sup>62</sup> and reporting, with a sense of pride, the long waiting lists they encountered in trying to check his books out of public libraries as proof that Dick-Read’s theories “were spreading and gaining favour among women themselves.”<sup>63</sup> These efforts were not limited to women. Maurice Dupont noted, for example, in a 1953 letter that he hoped that Dick-Read’s work would “find a wide public here” and assured the doctor, “I shall certainly tell everyone about it.”<sup>64</sup>

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<sup>60</sup> Joy Rames to Grantly Dick-Read, 22 July 1951.

<sup>61</sup> Katherine Passman to Grantly Dick-Read, 11 May 1951, and Dick-Read to Passman, 3 July 1951.

<sup>62</sup> Anne Weston to Grantly Dick-Read, 8 April 1953.

<sup>63</sup> Laurel Rice noted in 1955 that to check out a copy of *Childbirth Without Fear* in Toronto, “I had to place myself on a waiting list, and the period of time I had to wait was 3 months! Ample proof of your popularity. (As a token of my gratitude I am going to donate a copy of your book to the library. They really ought to have a dozen copies!).” Laurel Rice to Grantly Dick-Read, 24 May 1955.

<sup>64</sup> Maurice Dupont to Grantly Dick-Read, 15 April 1953.

At the same time, the movement enjoyed growing coverage in the Canadian popular press. A November 1952 article in support of Dick-Read's theories, entitled "No Anaesthetic for Me, Thanks," appeared in one of Canada's leading women's magazines, the *Canadian Home Journal*.<sup>65</sup> Beginning in December of the same year, *Childbirth Without Fear*, along with the "young and pretty" Canadian mothers who gave birth following these dicta, attracted the attention of Lotta Dempsey's "Person to Person" column in the *Globe and Mail*.<sup>66</sup> The *Globe* continued to cover the method in a favourable light throughout the decade.<sup>67</sup> By the mid-1950s, Natural Childbirth was a subject of increasing interest for many Canadians, as evidenced by a CBC broadcast on the issue in May of 1956.<sup>68</sup> The doctor himself answered women's questions on Natural Childbirth in a January 1958 piece in *Chatelaine*, noting that the movement had already attracted the attention of "many Canadian women," with the Canadian Mothercraft Society (CMS) offering "prenatal instruction based directly on Dick-Read's method."<sup>69</sup> Throughout the decade, the Toronto branch of the CMS remained instrumental in

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<sup>65</sup> "No Anaesthetic for Me, Thanks," *Canadian Home Journal* (November 1952), pp. 20, 68-69, 72-74. Geraldine Stowe to Grantly Dick-Read, 5 March 1953.

<sup>66</sup> Lotta Dempsey, "Person to Person," *The Globe and Mail*, 2 December 1952, p. 13; See also *The Globe and Mail* 5 January 1955, 22 January 1955, 11 February 1955, 10 May 1956,

<sup>67</sup> See, for examples, "More Mothers Get Prenatal Instruction," *The Globe and Mail*, 18 February 1953, p. 10; "Mothercraft Works for Family Life," *The Globe and Mail*, 7 March 1956, p. 13; Florence Schill, "Group is Enthusiastic About Natural Birth," *The Globe and Mail*, 28 March 1956, p. 15; "Readers' Comment: A Mystery What All the Fuss Is About," *The Globe and Mail*, 31 January 1957, p. 18. In this final article, Toronto mother Anna Davies wrote to *The Globe*, not to question "the fuss" surrounding Dick-Read's vision of natural childbirth, but rather, to take issue with the paper's viewpoint that "Childbirth Without Fear" represented a "new" trend. Davies argued instead that the method was relatively well-established, and that "demand for, and interest in, the methods expounded by Grantly Dick read is not lacking among young mothers today."

<sup>68</sup> Helen Scoles to Grantly Dick-Read, 28 May 1956.

<sup>69</sup> The fact that *Chatelaine* reached nearly two million Canadian readers per month during the 1950s and 1960s – the magazine's peak period of popularity – makes this piece particularly significant. See Valerie Korinek, *Roughing It in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties* (Toronto: University of Toronto Press, 2000), p. 3.

publicizing natural childbirth techniques, providing expectant patients with information on Dick-Read's theories using a variety of methods including lectures and film screenings.<sup>70</sup> In the same *Chatelaine* piece, however, the author, Evelyn Hamilton, commented on the ongoing reluctance on the part of some doctors working in Canada's "best hospitals" to discuss the method. Hamilton attributed this reticence to physicians' belief that the term "natural childbirth" gave the impression "that all births should be completely natural" – and as such, that the movement precluded any necessary intervention – in addition to the fact that doctors maintained "that no woman in labor can judge what should be done for her."<sup>71</sup>

By the postwar period, Dick-Read had lectured in the United States, and expressed a desire to visit Canada as early as 1947. It was the rising momentum of his theories over the course of the 1950s, however, that culminated in an extensive lecture tour that included several Canadian stops in late 1957 and 1958.<sup>72</sup> Growing public attention to the movement, particularly through such "official" channels like the Canadian Broadcasting Corporation, may have been helped by the fact that Dick-Read counted Dr. Ernest Couture, Director of the Division of Child and Maternal Health in the Department of National Health and Welfare among his Canadian supporters, suggesting

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<sup>70</sup> Grantly Dick-Read to Betty Daniels, 23 December 1955.

<sup>71</sup> Evelyn Hamilton, "Dr. Grantly Dick Read answers your questions on NATURAL CHILDBIRTH," *Chatelaine* (January 1958), p. 17.

<sup>72</sup> In a 1947 letters to Mrs. George Spark and L.B. Miller, Dick-Read commented: "I do not like going to America and not to Canada," and "I hope that one day I shall be invited to Canada, even as I was to America. My visit there at the beginning of this year demonstrated a thousandfold how wholehearted this desire is in the minds of the men and women of our time." Grantly Dick-Read to Mrs. George Spark, 5 January 1947, and Grantly Dick-Read to L.B. Miller, 23 October 1947.

that Canadian letter writers to contact him for additional information on natural childbirth.<sup>73</sup>

While the natural childbirth movement was indeed popular among the lay public, historians have questioned how revolutionary Natural Childbirth ideologies actually were. Despite their critiques of certain aspects of the medical system, Canadian letter writers continued to articulate conservative views of women's role in the family, society, and the medical sphere, and consistently upheld maternity as women's highest purpose and the foundation of the family. Women, in particular, described their "fundamental yearnings" to bear children, despite previous traumatic experiences,<sup>74</sup> and spoke to the spiritual value of motherhood.<sup>75</sup> Although they did voice their opposition to what they saw as some of the most troublesome aspects of medicalization, correspondents largely refrained from challenging the authority of the physician. Of course, there were exceptions to this trend. Karen Birch wrote to Dick-Read of her plan to "try and instruct (!) [her] doctor in natural childbirth" should she become pregnant for a fourth time, but her inclusion of an exclamation mark in parenthesis implies that she recognized that there was something unconventional – or at the very least, remarkable – about such a

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<sup>73</sup> In a 1951 letter to Mr. and Mrs. Spencer of Ottawa, for example, Dick-Read remarked that Couture had visited him in Woking, and commented "he is, I believe, a powerful supporter of my tenets, which I understand are rapidly taking hold in Canada." Grantly Dick-Read to Mr. and Mrs. Spencer, 30 January 1951. I plan to further explore the relationship between Canadian physicians and Dick-Read as part of the next stages of this project during my tenure as a postdoctoral fellow.

<sup>74</sup> Despite her negative memories of her first three "miserable" pregnancies and deliveries, Karen Birch repeatedly described her conviction that maternity was her highest purpose, writing: "I craved a baby as an addict craves his cocaine. It was a deep, fundamental yearning and I was ready to go thru [sic] Hell all over again just to have another little baby." Birch to Dick-Read, 12 October 1948.

<sup>75</sup> Helen Carter spoke to the spiritual importance of maternity during this period, in her 1951 letter, writing: "the night that my young son was born was one of the most spiritually rewarding that I shall ever know." Helen Carter to Dick-Read, 8 June 1951.

suggestion.<sup>76</sup> More legitimate challenges to medical authority often came from men, themselves occupying a position of power and authority within patriarchal family structures. Maurice Dupont, for example, recalled that during his wife's first delivery in the spring of 1953, "the doctor was cooperative but unfamiliar" with Dick-Read's methods. As labour progressed, Mr. Dupont recounted that he "had to restrain" the attending physician "from giving an anaesthetic towards the time of delivery."<sup>77</sup> It is difficult to imagine a parturient patient carrying out a similar intervention on her own behalf in the birthing room. As might be expected, given the doctor-patient power relationship, women writers, in particular, tended to be quite deferent toward Dick-Read, giving him (sometimes sole) credit for their "achievements," and apologizing for taking up his time with their letters.<sup>78</sup> Hattie Jones, for example, closed a letter by commenting, "I know you are very busy, so please don't take the time to answer this."<sup>79</sup> On his part, Dick-Read also cast himself in a position of authority over his patients.<sup>80</sup>

The continuation of traditional doctor-patient power dynamics in the early natural childbirth movement is not entirely surprising. Though proponents of natural birth offered their audience, at times, new messages on the nature of birth and the events

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<sup>76</sup> Karen Birch to Grantly Dick-Read, 12 October 1948.

<sup>77</sup> Maurice Dupont to Grantly Dick-Read, 15 April 1953.

<sup>78</sup> Describing the successful Natural Childbirth experience of a friend, Lorraine Blair remarked that although the nurses had congratulated the new mother after the delivery, "I think that the compliments should go to the Doctor who has worked and is still working to make childbirth the natural and inspiring thing that it is." Lorraine Blair to Grantly Dick-Read, 28 November 1950. Kathleen Williams went as far as to thank Dick-Read by name in the 1949 announcement of the birth of her fourth child, and included a copy of the newspaper clipping in her letter to the doctor. Kathleen Williams to Grantly Dick-Read, 3 September 1949.

<sup>79</sup> Hattie Jones to Grantly Dick-Read, 12 January 1951.

<sup>80</sup> This was the case for husbands and wives alike. Writing to a female correspondent in Edmonton in 1951, Dick-Read agreed with the letter writer on the importance of a husband's supportive attitude during labour, and noted that he "put it to [all husbands] quite plainly that he must be interested in this." Grantly Dick-Read to Ruth Adams, 2 July 1951.

taking place in the birthing room, those physicians supporting the movement continued to recognize the importance of carefully considering and curating the amount and nature of the information they presented to their expectant patients. The Canadian medical profession's reaction to Dick-Read's 1953 film *Childbirth without Fear* provides a good example of these ongoing concerns. In late 1955, Betty Daniels, writing on behalf of other Canadian mothers, expressed the belief that a film would do much "to make the principles of natural childbirth more widely known" throughout the Western World, and unaware of Dick-Read's previous endeavors, encouraged the doctor to produce such an offering.<sup>81</sup> Dick-Read was pleased to respond to Daniels that he had, in fact, made such a film "that shows the actual delivery of three natural childbirths in succession." He noted that this 20 minute offering had been recently screened by the Toronto branch of the Canadian Mothercraft Society to a large audience of "over eighty persons, both husbands and wives." Additionally, he was pleased to report that a gramophone record focusing on antenatal preparation and the sounds of birth was also "in the course of preparation."<sup>82</sup>

Though Dick-Read took advantage of these new forms of communication to offer information to expectant mothers, Canadian medical professionals appeared to suggest that Dick-Read's *Childbirth without Fear* pushed the boundaries in terms of the amount of knowledge and information it was appropriate to offer lay audiences regarding the nature of birth. The *CMAJ*'s 1953 review of the film deemed it suitable for "medical students in the clinical years, and for nurses" as well as for showing by "obstetricians practicing natural childbirth to parents who wish to see it and who the doctor feels may

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<sup>81</sup> Betty Daniels to Grantly Dick-Read, 13 December 1955.

<sup>82</sup> Grantly Dick-Read to Betty Daniels, 23 December 1955. This record was released in 1956.

benefit by it.” Given the involvement of trained nurses in the organization, the CMS’s screenings of the film may have, perhaps, fallen into the latter of these categories.

*Canadian Medical Association Journal* reviewers and editors, however, were careful to point out that the film - though freely available from a Toronto distributor – was “unsuitable for non-medical audiences, except as indicated above.”<sup>83</sup>

Ultimately, then, it is important to keep in mind that Dick-Read’s version of Natural Childbirth was still medicalized birth. While the growing emphasis on maternity as an emotional rather than a wholly physical experience for women led a larger number of physicians to view birth in a new light, childbirth was still seen as a period of a woman’s life that required medical training, management, and supervision – control that was now focused on the emotional, as well as the physical aspects of pregnancy.<sup>84</sup> Women who wrote to Dick-Read about their “successful” natural deliveries, defined this success in various ways, many of which included varying degrees of medical intervention. Kathleen Williams had “insisted” that she “didn’t want ether or anything” before the delivery of her fourth child in 1949, but told Dick-Read that “things happened so quickly that I was forced to ‘take a whiff’ to slow things down.” Nevertheless, she described herself as “another happy mother” who was satisfied with both the method and her natural birth.<sup>85</sup> Katherine Passman, who wrote to Dick-Read in 1951, recounted that she had received ether and Demerol during her delivery, but that she still found it a

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<sup>83</sup> “Medical Films,” *CMAJ* 69, no. 4 (October 1953), p. 579. Emphasis in original text.

<sup>84</sup> Historians have argued that psychosomatic approaches to the pain of giving birth, including Dick-Read’s theories, “did not move childbearing out of the medical realm.” See Sandelowski, *Pain, Pleasure and American Childbirth*, p. 60.

<sup>85</sup> Kathleen Williams to Grantly Dick-Read, 3 September 1949.



success.<sup>86</sup> And finally, despite her negative experience of being anaesthetized against her will, and her recognition that “the final triumph in actually delivering my baby (without ether), which I so anticipated, was denied,” Laurel Rice recalled her birth experience in a positive light. She wrote to Dick-Read: “I am very happy that the delivery was so easy. It is to you I give all the credit. Your words, your teachings, your complete understanding of labour (physically and emotionally) helped me accomplish what amazes even me.”<sup>87</sup>

### Conclusion

In her classic American study, Sandelowski writes that “in the 1940s and 1950s, Natural Childbirth was the Read method and no other.”<sup>88</sup> Accordingly, while Dick-Read found a captive audience in those who were interested in a new way to birth, he was, in turn, the natural audience for Canadian women and men interested in the principles and practice of alternative techniques, some of whom felt compelled to write to a physician for the first time.<sup>89</sup> By writing to Dick-Read, Canadians demonstrated their engagement with this broader international medical movement. In voicing their opinions, and at times, outright opposition to medicalization, letter writers compel us to question our

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<sup>86</sup> Passman recalled: “...I had to have some ether so the baby wouldn’t be born until [the doctor] could arrive. I was not too uncomfortable as they just gave me enough ether to help me control the contractions...They had also given me an injection of Dimerol [sic]. It wasn’t long till Dr. Green was there and ready. I had a little ether with the next contraction and the head was born, it was a very great relief and right away the rest of the body was born (without any discomfort whatsoever) and I heard the baby cry (it was a great thrill)...I was overjoyed. I think Dr. Green was very impressed.” Katherine Passman to Grantly Dick-Read, 11 May 1951.

<sup>87</sup> Laurel Rice to Grantly Dick-Read, 24 May 1955

<sup>88</sup> Sandelowski, *Pain, Pleasure and American Childbirth*, 98.

<sup>89</sup> Edith Zimmerman, of Montreal, for example, wrote in 1950 “I have never in my life before bothered or written to any busy person, particularly a doctor, but this matter is out of the ordinary, and I could have no confidence in any other type of doctor.” Zimmerman to Dick-Read, 17 July 1950.

assumptions about the nature of the doctor-patient power relationship in the postwar period. Women (and men) were not passive consumers of either mainstream medical rhetoric or alternative medical ideologies; in writing to Dick-Read, Canadians actively sought out and created new spaces where they engaged with, debated, and discussed these ideas. And, perhaps most significantly, despite the conservatism of the early Natural Childbirth movement in terms of its ongoing emphases on a traditional, maternal role for women, and the persistence of many elements of medicalized birth, these letters provide a window into some of the first major opposition to the continued medicalization of birth, marking the beginnings of an end to the unquestioned use of obstetric anaesthesia.

## Conclusion

### The Nature and Meaning of Birth Pangs

In the two decades since the early 1990s, when midwifery was effectively re-integrated into the Canadian health care system after a century of marginality and even illegality, advocates of “natural” versus “modern” medicalized childbirth have been increasingly at odds.<sup>1</sup> Women have always retained agency in their encounters with medical practitioners, but now, many can assert more of their own authority in choosing how to give birth. Today, some schedule their deliveries and elect to give birth by caesarean section. At the same time, women’s greater agency is also exemplified by the resurgence of certain aspects of more traditional and female-dominated birthing cultures. For many, this includes the choice to give birth in their own homes, with the assistance of a trained midwife and/or doula rather than a physician. As this study has demonstrated, each of these trends – the medicalization of birth, and the emergence of the contemporary natural birth movement – has its own historical roots and is grounded in the particular notions of gender and maternity that prevail in any historical moment.

This study explored the history of professional and popular medical ideas about women’s bodies, childbirth, and pain over the course of the late nineteenth and early twentieth centuries. Throughout much of the period under discussion, the trope of the “delicate woman” dominated mainstream Canadian medical discourses. As the prevalent

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<sup>1</sup> In Ontario, midwifery became a legal and officially recognized profession and was integrated into the provincial health care system in 1993, with the province offering an “internationally renowned” model for integration. While Ontario was the first province to professionalize and integrate midwifery practice, other provinces have since followed suit. For more information, see Ivy Lynn Bourgeault, *Push! The Struggle for Midwifery in Ontario* (Montreal and Kingston: McGill-Queen’s University Press, 2006).

medical perception of the female body held that white, middle and upper-class, and urban-dwelling women were especially sensitive to the pain of giving birth, the construction of female “delicacy” was underpinned by a variety of gendered, class-based, and racialized distinctions that were inseparable from turn-of-the-twentieth century social tensions. Ideas about the delicate female emerged as part of a broader cultural milieu that included deeply-felt anxieties surrounding the seemingly ever-increasing dangers posed by immigration, urbanization, and technological change. Alongside the growing prevalence of eugenic theories, these tensions coalesced around discussions of the threats that delicacy and sensitivity to pain – broadly construed – posed to the Anglo-Canadian race. These arguments – as well as the increasingly pathological views of both pregnancy and birth that went hand in hand with this particular construction of the female body – contributed to the growing medicalization of birth, the greater acceptance and use of obstetric anaesthesia, and the increased social authority of the predominantly male medical profession during these transformative decades.

The state of obstetric education in Canadian medical schools throughout this period left much to be desired, with many students, well into the interwar years, regularly receiving medical degrees without any significant experience in the birthing room. In this atmosphere, young practitioners recalled that they often felt lost when approaching the confinements of their first expectant patients. This sense of professional unease has certainly extended beyond this particular historical period – recent studies suggest that, even today, many young doctors are “painfully aware of the gaps in their knowledge,” a

recognition that “can be paralyzing” to the new practitioner.<sup>2</sup> As participants in the professionalization of obstetrics, however, late nineteenth and early twentieth century physicians were, in the face of these anxieties, nonetheless required to articulate their expertise in obstetrics relative to both their expectant patients and other figures present in the birthing room. These figures included midwives and nurses of varying levels of training, as well as, on some occasions, the families and friends of their expectant patients.

Given the lack of training in obstetrics at many Canadian medical schools, professional medical discourses played a major role in shaping physicians’ attitudes towards the female body, pregnancy, parturition, and their associated experiences of pain. Ideas about female delicacy consistently underpinned the ways in which English-Canadian physicians described these subjects. While, generally speaking, most Canadian practitioners viewed all female bodies and reproductive processes in an increasingly pathological light, the bodies, pregnancies, and births of certain women – dependent on perceived class, age, and racial differences – were cast as particularly problematic. In much of the mainstream medical literature produced throughout this period, the notion of “civilization” (or perceived lack thereof) stands out as a recurring theme when it came to determining which groups of women suffered most acutely from bodily discomforts of all types, but especially, “birth pangs.”<sup>3</sup> In mastering the pathologized bodies and births of the exquisitely sensitive white, middle and upper-class, urban-dwelling women who

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<sup>2</sup> Jessica Leigh Hester, “The Misery of A Doctor’s First Days,” *The Atlantic* (1 October 2015) Accessed 2 October 2015. <http://www.theatlantic.com/health/archive/2015/10/the-misery-of-a-doctors-first-days/408004/>

<sup>3</sup> See Bourke, *The Story of Pain*, p. 199.

made up the bulk of their patients, doctors demonstrated their professional authority and expertise relative to other medical practitioners – namely, midwives and nurses.

Physicians' increasing acceptance, innovation, and employment of a growing obstetric anaesthesia arsenal was a key part of this process. As Canadian doctors embraced the possibilities of pain relief in the birthing room, a stance that appears to have been adopted by the majority of mainstream medical practitioners by the first decades of the twentieth century, the prestige of obstetrics further increased. Medical perspectives on the value of medicalized birth and the hierarchical distinctions between “delicate” and “natural” women – between “civilized” and “primitive” bodies and births – were effectively transmitted to lay audiences via a growing body of widely popularized prescriptive literature published in the late nineteenth and early twentieth centuries.

This medical rhetoric was inseparable from how women in turn-of-the-century English Canada viewed their own bodies and birth experiences. Though many were generally reticent to discuss such matters, even in their diaries and private correspondence, the women whose records have survived tended to frame pregnancy and parturition in ways that both echoed and fuelled many of the arguments made in prevailing medical discourses – they dreaded the heightened pain they were expected to experience in giving birth, and described their pregnancies and deliveries using the pathological language of the period. Medical discourses, then, both reflected and reinforced the “delicate” woman's fear of childbirth, and shaped individual recollections of birth experiences. Fundamentally, pervasive fears of pregnancy, and of the uncertainty and pain associated with giving birth, contributed to women's increasing recourse to “modern” physician assistance during the birthing process. The outcome was a very

different personal experience of pregnancy and birth for white, middle-class women, the ongoing elimination of midwife attendance, and the burgeoning professionalization of obstetrics in English Canada.

In some ways, the growing popularity of natural childbirth ideologies in the 1940s and 1950s represented a significant shift and some of the first substantial and organized opposition to the medicalization of childbirth that had been ongoing since the second half of the nineteenth century. Ultimately, however, those proponents of the early natural birth movement who supported the tenets and ideas put forward in British obstetrician Grantly Dick-Read's *Childbirth Without Fear* (1944) continued to articulate conservative views of the female body, birth, and the doctor-patient power relationship. Canadian mothers, some of whom were anaesthetized against their will to prevent untimely deliveries beyond a physician's control, defined the "success" of their natural births in a variety of ways. For many women, a successful natural birth included considerable medical intervention, including the provision of anaesthesia or other drugs during delivery. Nevertheless, the fact that women defined their Dick-Read-inspired births as natural, and framed them in opposition to the majority of medicalized births in the postwar period, is significant. Though representative of only a small subset of the general population, the experiences of Dick-Read's Canadian correspondents suggest the beginning of the end of the first heyday of obstetric anaesthesia.

Medical texts and journals can offer rich opportunities to study the construction of the delicate woman and begin to unpack the broader historical implications of her perceived sensitivity to pain. These sources, however, are often silent when it comes to many key viewpoints. First, the perspectives of those practitioners who did not ascribe to

mainstream medical views are largely neglected in many of the leading medical texts produced during the late nineteenth and early twentieth centuries, and only rarely included in the periodical literature. The views of female physicians, who made up a small but growing segment of the Canadian medical profession, are similarly underrepresented throughout much of the period under study. Historians need to remain mindful of the ongoing potential for disconnect between what the medical literature says and what doctors actually did in their day to day practice. More importantly, these materials offer a particular medicalized interpretation of the female body that often has the potential to overshadow records in which women have presented their own accounts of the lived experiences of pregnancy and birth. While sources created by those women who sought out medicalized birth during these transformative decades do exist, those that survive overwhelmingly represent the perspectives of only a narrow group of English Canadians. Accordingly, more work needs to be done to uncover the voices of women across the class and race divide. While working-class mothers and mothers to be have entered the historical record as the targets of growing medical surveillance and regulation over the first half of the twentieth century, and often aspired to “modern” and medicalized birth experiences, sources (including diaries and correspondence) in which these women offer their own perspectives are harder to come by. So too are the voices of “racialized” women, who often had limited contact with mainstream medical practitioners and were more likely to have entered the historical record as the subjects of ethnographical research.<sup>4</sup>

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<sup>4</sup> Mitchinson has argued that the medicalized “contact zone” was often “very limited between the vast majority of Canadian practitioners and women who were deemed ‘racialized’... As for the



This study has unpacked medical constructions of the delicate female body, and has begun to touch on the broader cultural and personal impacts of such discourses. More work, however, needs to be done towards the latter focus. How did these discourses impact how individual physicians actually treated their parturient patients? How did cultural representations of female sensitivity depart from medical discourses? How did different groups of women see and experience their own pregnancies and births? How did they make sense of pain after delivery, as the presence of a new child (or, alternatively, the death of a child during or shortly after birth) compelled them to revisit the birth experience and reconceptualize the meaning of childbirth pain? How did female communities, into the twentieth century, understand and make sense of the “birth pangs” that all English-Canadian mothers were thought to experience? Finally, how did men perceive the labour pains of the women in their lives? As the history of pain remains an embryonic field, much work remains to be done on these questions. Furthermore, greater attention to the natural birth movement – a movement that continued to gain momentum in the 1960s and 1970s and has since become a mainstream practice – allows scholars to continue to historicize and problematize perceptions of the female body, pain, and childbirth. The beginnings of a historical examination of natural childbirth in English Canada raises its own questions, but also offers the exciting opportunity, through oral history, to incorporate the voices of women who gave birth in the second half of the twentieth century into the picture. I am incredibly grateful to have the opportunity to

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racialized women themselves, silence on certain aspects of their bodily experience is strong.” Mitchinson, *Body Failure*, p. 7.

pursue these lines of inquiry, and as such, a more comprehensive picture of the history of childbirth pain, over the coming years.

As the preceding chapters demonstrate, medical and popular attitudes about the ways in which different groups of women experienced the discomforts and “birth pangs” associated with pregnancy and parturition are inseparable from the broader gender, class-based, and racial stereotypes and tensions of any given period. Attention to the effects of these attitudes on medical practice and the treatment individuals receive, however, is also lacking. John Hoberman has argued that many practitioners continue to approach the issue of medical racism “through a euphemistic vocabulary that is meant to insulate physicians from direct responsibility for racist behaviour.” By ascribing differential treatments to “cultural differences” and “patient preferences” rather than professional decisions, medical discourses continue to perpetuate the idea that “delivery systems,” rather than “doctors,” are “unfriendly to members of certain cultures.”<sup>5</sup>

Keeping in mind contemporary research suggesting that women perceive themselves to be the more sensitive sex, the effects of gender on medical treatment are equally significant. While medical emphases on female sensitivity can, on some occasions, privilege women as patients, they can also have markedly negative effects on women’s encounters with the health care system. In an October 2015 piece in *The Atlantic*, author Joe Fassler argued that doctors and other medical professionals continue to take women’s pain less seriously than that of men, especially when the corporeal

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<sup>5</sup> Hoberman, “The Primitive Pelvis,” pp. 96-97.

complaints of female patients can be traced back to the reproductive organs.<sup>6</sup> The effects of this potential condescension, like pain itself, are private and subjective, but often deeply felt. Research into the historical and cultural construction of these attitudes remains an important undertaking.

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<sup>6</sup> Fassler's account of his wife's experiences with ovarian torsion, an acute condition creating "the kind of organ-failure pain few people experience and live to tell about", has since prompted other women to share their personal stories of how their pain has been "dismissed, downplayed, or misdiagnosed" by medical professionals. Joe Fassler, "How Doctor's Take Women's Pain Less Seriously," *The Atlantic* (15 October 2015) Accessed 16 October 2015. <http://www.theatlantic.com/health/archive/2015/10/emergency-room-wait-times-sexism/410515/> See also, "Stories of Misunderstanding Women's Pain," *The Atlantic*. Accessed 5 November 2015. <http://www.theatlantic.com/notes/all/2015/10/stories-of-misunderstood-womens-pain/411793/>

## **Bibliography**

### *Primary Sources*

#### Archival Sources

Archives of Manitoba, Winnipeg, MB

Winnipeg Past and Present Oral History Project Collection

Archives of Ontario, Toronto, ON

Clifford Hugh Smylie Fonds, MU 2853

Frances (Tweedie) Milne Papers, Diary of Frances Milne, MU 866

James C. Goodwin Collection, MU 7543

Oswald Withrow Papers, MU 7540

British Columbia Archives, Victoria, BC

Nellie Bolton Fonds, PR-1569

Glenbow Museum and Archives, Calgary, AB

Eliza Jane Wilson Fonds, M 1320

Hamilton Public Library, Local History and Archives Department, Hamilton, ON

Brown-Hendry Collection

Library and Archives Canada, Ottawa, ON

Canadian Medical Association Fonds, Medical Sections, MG 28 I 343

Section on Anaesthesia, 1927-1955, Volume 5

Section of Obstetrics and Gynaecology, Volume 6

Harry Tremaine Logan and Family Fonds, MG 30 C215

JEG Curran Fonds, MG 30 C85

Osler Library for the History of Medicine, Montreal, QC

Archibald Daniel Campbell Fonds, P 174

Jack Elmer Harrison Fonds, P 173

John Clarence Webster Fonds, P 011

Toronto Reference Library, Baldwin Special Collections, Toronto, ON

Diary of Mary Coldwell Butcher, 1891-1929

Diary of Emma Laflamme, 1886-1887

Wellcome Library for the History of Medicine, London, UK

Grantly Dick-Read Collection, PP/GDR

National Birthday Trust Fund Collection, SA/NBT

Sir Weldon Dalrymple-Champneys Collection, GC/139/C.2

Western University Archives Research and Collections Centre, London, ON

J.M. Smith Papers, A00-194-01

### Journals, Newspapers, Magazines

*British American Journal of Medical and Physical Science*, 1850  
*Canadian Home Journal*, selected articles  
*Canadian Journal of Medicine and Surgery*, 1897-1936  
*Canadian Journal of Public Health*, 1929-1942  
*Canada Lancet*, 1863-1922  
*Canada Lancet and National Hygiene*, 1922-1925  
*Canada Lancet and Practitioner*, 1925-1934  
*Canadian Medical Association Journal*, 1911-1955  
*Canada Medical Journal and Monthly Record of Medical and Surgical Science*, 1864-1872  
*Canada Medical Record*, 1872-1904  
*Canadian Public Health Journal*, 1943-1950  
*Chatelaine*, selected articles  
*Dominion Medical Monthly and Ontario Medical Journal*, 1895-1921  
*Public Health Journal*, 1910-1928  
*Queen's Medical Quarterly*, 1903-1909  
*The Canadian Medical Review*, 1895-1898  
*The Globe and Mail*, selected articles  
*Western Canadian Medical Journal*, 1907-1915  
*University of Toronto Medical Journal*, 1923-1950

### Published Primary Sources

Alexander, Howard J. *56 Years in Medical Practice*. Compiled and Edited by Frank Fubie. Tillsonburg, ON: Bennet Stationary Ltd., 1981.

Allbutt, H. Arthur. *The Wife's Handbook: How a Woman Should Order Herself during Pregnancy, in the Lying-In Room, and After Delivery*. London: W. J. Ramsey, 1886.

Beard, George M. *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*. New York: B.B. Treat, 1889.

Bedford, Gunning. *The Principles and Practice of Obstetrics*. New York: Samuel S. & William Wood, 1861.

Berkeley, Comyns and Victor Bonney. *The Difficulties and Emergencies of Obstetric Practice*. Toronto: The MacMillan Company of Canada, Ltd., 1921.

Bigelow, Wilfred Abram. *Forceps, Fin & Feather: The Memoirs of Dr. W.A. Bigelow*. Altona, MB: Frieson & Sons, 1970.

- Bland-Sutton, J. and Arthur E. Giles. *The Diseases of Women: A Handbook for Students and Practitioners*. 5<sup>th</sup> Edition. London and New York: Rebman, 1906.
- Byford, Henry Turman. *Manual of Gynaecology*. Philadelphia: P. Blakiston, Son & Co., 1895.
- Byford, William Heath. *A Treatise on the Theory and Practice of Obstetrics*. New York: William Wood & Co., 1870.
- Campbell, Archibald D. and Mabel A. Shannon. *Gynaecology for Nurses*. Philadelphia: F.A. Davis Company, 1946.
- Chavasse, Pye Henry. *Advice to a wife on the management of her own health, And on the Treatment of Some of the Complaints Incidental to Pregnancy, Labour and Suckling, with an Introductory Chapter Especially Addressed to a Young Wife*. Toronto: The Hunter, Rose Company, 1879.
- Cooke, Joseph Browne. *A Nurse's Handbook of Obstetrics: For Use in Training Schools*. Philadelphia and London: J.P. Lippincott, 1907.
- Crossen, Harry Sturgeon. *Diseases of Women*. St. Louis: C.V. Mosby Company, 1917.
- Davis, Carl Henry. *Painless Childbirth Eutocia and Nitrous Oxid-Oxygen Analgesia*. Chicago: Forbes and Company, 1916.
- DeLee, Joseph B. *Obstetrics for Nurses*. Philadelphia: W.B. Saunders Co., 1904.
- *The Principles and Practice of Obstetrics*. Philadelphia: W.B. Saunders, 1913.
- Dick-Read, Grantly. *Childbirth Without Fear: The Principles and Practice of Natural Childbirth*. New York: Harper and Brother Publishers, 1944.
- Drake, Emma F. Angell. *Maternity Without Suffering*. Toronto: William Briggs, 1902.
- Dudley, Emilius Clark. *The Principles and Practice of Gynaecology for Students and Practitioners*. 5<sup>th</sup> Edition. Philadelphia and New York: Lea & Febiger, 1908.
- Dye, John H. *Painless Childbirth, or Healthy Mothers and Healthy Children: A Book for All Women*. Seventeenth Edition. Buffalo: Dr. J.H. Dye Medical Institute, 1912.
- Eden, Thomas Watts. *A Manual of Midwifery* Toronto: The MacMillan Company, 1915.
- Edgar, J. Clifton. *The Practice of Obstetrics: Designed for the Use of Students and Practitioners*. Philadelphia: P. Blakiston's Son & Co., 1907.
- Engelmann, George J. *Labor among Primitive Peoples: Showing The Development of the Obstetric Science of To-Day from the Natural and Instinctive Customs of All Races, Civilized and Savage, Past and Present*. St. Louis: J.H. Chambers, 1882.

- Every Woman Her Own Doctor: A Complete Book in Plain English Concerning Ailments and Accidents to which Women and Children are Liable and their Cure, By a Fully Qualified MD.* London: C. Arthur Pearson, Ltd., 1903.
- Fairbairn, John S. *Gynaecology with Obstetrics: A Text-Book for Students and Practitioners.* Toronto: Oxford University Press, 1924.
- Fenwick, Kenneth Neander. *Manual of Obstetrics, Gynaecology and Pediatrics.* Kingston: John Henderson & Co., 1889.
- Flexner, Abraham. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching.* Carnegie Foundation for the Advancement of Teaching, 1910.
- Fuher, Charlotte. *The Mysteries of Montreal: Memoirs of a Midwife.* Ed. W. Peter Ward. Vancouver: University of British Columbia Press, 1984.
- Garrett, R. W. *Text Book of Medical and Surgical Gynaecology: For the Use of Students and Practitioners.* Second Revised Edition. Kingston, ON: R. Uglow & Co., 1910.
- Garrigues, Henry J. *Gynaecology: Medical and Surgical – Outlines for Students and Practitioners.* Philadelphia: J.B. Lippincott and Company, 1905.
- Gilliam, David Tod. *A Text-Book of Practical Gynecology: For Practitioners and Students.* Philadelphia: F. A. Davis, 1907.
- Girlhood and Wifehood: Practical Counsel and Advice, By a Surgeon & Accoucheur, Member of the Royal College of Surgeons, London.* London: The “Family Doctor” Publishing Company, 1896.
- Graves, William P. *Gynecology.* Philadelphia and London: W.B. Saunders, 1918.
- Green, Charles M. *Diseases of Women Including Abnormalities of Pregnancy, Labor, and the Puerperium: A Clinical Study of Pathological Conditions Characteristic of the Five Periods of Woman’s Life (Presented in One Hundred and Seventy-Three Case Histories).* Boston: W.M. Leonard, 1920.
- Groves, Abraham. *All in the Day’s Work: Leaves from a Doctor’s Casebook.* Toronto: The MacMillan Company of Canada, Ltd., 1934.
- Harland, Marion. *Eve’s Daughters; or Common Sense for Maid, Wife and Mother.* Toronto: Rose Publishing Company, 1882.
- Harms, Heidi and Katherine Martens. *In Her Own Voice: Childbirth Stories from Mennonite Women.* Winnipeg: University of Manitoba Press, 1997.

- Harrington, Charles. *A Manual of Practical Hygiene for Students, Physicians, and Health Officers*. Philadelphia: Lea and Febiger, 1914.
- Harris, Robin S. and Terry G. Harris, eds. *The Eldon House Diaries: Five Women's Views of the Nineteenth Century*. Toronto: University of Toronto Press and the Champlain Society, 1994.
- Hilger, Mary Inez. *Chippewa Child Life and Its Cultural Background*. St. Paul: Minnesota Historical Society Press, 1951, Reprint 1992.
- Hirst, Barton Cooke. *A Text-Book of Obstetrics*. Philadelphia and London: W.B. Saunders Company, 1912.
- Holbrook, M.L. *Parturition without Pain.: A code of directions for escaping from the primal curse*. Toronto: Maclear, 1875.
- Hutton, Samuel King. *Health Conditions and Disease Incidence Among the Eskimos of Labrador*. London: The Wessex Press, 1925.
- Jellett, Henry. *A Manual of Midwifery for Students and Practitioners*. New York: William Wood & Co., 1910.
- Johnston, William Victor. *Before the Age of Miracles: Memoirs of a Country Doctor*. New York: Paul S. Eriksson, Inc., 1972.
- Kerr, J.M. et al. *Combined Text-Book of Obstetrics and Gynaecology for Students and Medical Practitioners*. Edinburgh: E. & S. Livingstone, 1923.
- Lusk, William Thompson. *The Science and Art of Midwifery*. New York: D. Appleton & Co., 1888.
- MacLean, Donald. *On the Medical Profession and Medical Education in Canada: Address Delivered at His Instillation as Professor of the Institutes of Medicine, Queen's University, January 10, 1865*. Kingston: 1865.
- MacMurchy, Helen. *How to Take Care of the Mother: Little Blue Books, Home Series*. Ottawa: F.A. Acland, Printer to the King's Most Excellent Majesty, 1922.
- *Need Our Mothers Die? A Study Made by a Special Committee of the Division on Maternal and Child Hygiene*. Ottawa: Canadian Welfare Council, 1935.
- *The Canadian Mother's Book*. Ottawa: Thomas Mulvey: Printer to the King's Most Excellent Majesty, 1921.
- McLean, John. *Canadian Savage Folk: The Native Tribes of Canada*. Toronto: William Briggs, 1896.
- *The Indians: Their Manners and Customs*. Toronto: William Briggs, 1889.



- Meigs, Charles D. *Obstetrics: The Science and The Art*. Philadelphia: Blanchard and Lear, 1852.
- Melendy, Mary R. *Ladies Home Companion A Book Giving Full Information on all the Mysterious and Complex Matters Pertaining to Women*. Brantford: The Bradley Garretson Co., 1903.
- Morice, A.G. *The Western Denes: Their Manners and Customs*. Toronto: The Copp Clark Company, Limited, 1889.
- Napheys, George Henry. *The Physical Life of Woman: Advice to the Maiden, Wife and Mother*. Toronto: Maclear and Company, 1875.
- Peikoff, Samuel S. *Yesterday's Doctor: An Autobiography*. Winnipeg: The Prairie Publishing Company, 1980.
- Penrose, Charles. *A Text-Book of Diseases of Women*. 5<sup>th</sup> Edition. Philadelphia, New York, and London: W.B. Saunders & Company, 1904.
- Playfair, William Smoult. *A Treatise on the Science and Practice of Midwifery*. Philadelphia: Henry C. Lea, 1876.
- Reed, Charles A.L. *A Text-Book of Gynaecology*. New York: D. Appleton and Co., 1901.
- Reid, Agnes Just. *Letters of Long Ago*. Caldwell, Idaho: Caxton Printers, 1936.
- Rion, Hanna. *The Truth About Twilight Sleep*. New York: McBride, Nast, and Company, 1915.
- Saur, Prudence B. *Maternity: A Book for Every Wife and Mother*. Chicago: L.P. Miller and Company, 1887.
- Scott, William Albert, and H. Brookfield Van Wyck. *The Essentials of Obstetrics and Gynaecology*. Philadelphia: Lea & Febiger, 1947.
- Scovil, Elisabeth Robinson. *Preparation for Motherhood*. Philadelphia: Henry Altemus, 1896.
- Smith, A. *Twilight Sleep in America: The Truth about Painless Childbirth*. New York: The Victor Publishing Company, 1915.
- Smylie, Clifford Hugh. *Northern Doctor: Memoirs of Clifford Hugh Smylie, MD*. Cobalt: Highway Books, 1979.
- Springett, Evelyn Cartier. *For My Children's Children*. Montreal: The Unity Press, 1937.
- Stockham, Alice B. *Tokology: A Book for Every Woman*. Toronto: McClelland and Goodchild, Ltd., 1893.

- The Canadian Council of Women and Victorian Order of Nurses. *Woman: Maiden, Wife, and Mother – A Study of Woman's Worth and Work in All Departments of Her Manifold Life, Education, Business, Society, Housekeeping, Health, Physical Culture, Marriage, and Kindred Matters*. Toronto: The Linscott Publishing Company, 1898.
- The Ladies' Book of Useful Information*. London, ON: London Printing and Lithographing Co., 1896.
- The Ladies Physician: A Guide for Women in the Treatment of their Ailments, By a London Physician*. London: Cassel and Company, Ltd., 1886.
- The Selected Journals of L.M. Montgomery, Volume II: 1910-1920*. Eds. Mary Rubio and Elizabeth Waterson. Toronto: Oxford University Press, 1987.
- Thomas, T.G. *Notes from Lectures on Obstetrics*. New York: John J. O'Brien, Steam Book & Job Printer, 1878.
- Victorian Women: A Documentary Account of Women's Lives in Nineteenth-Century England, France, and The United States*. Eds. Erna Oilafson Hellersten, Leslie Parker Hume, and Karen M. Offen. Stanford: Stanford University Press, 1981.
- Warren, Ira. *Warren's Household Physician*. Boston: Ira Bradley & Company, 1884.
- Williams, J. Whitridge. *Obstetrics: A Textbook for the Use of Students and Practitioners*. 6<sup>th</sup> Enlarged and Revised Edition. New York and London: D. Appleton and Company, 1931.
- Willinsky, A.I. *A Doctor's Memoirs*. Toronto: The MacMillan Company of Canada, Ltd., 1960.
- Wright, Adam H. *A Text-Book of Obstetrics*. New York and London: D. Appleton and Company, 1908.
- Ulrich, Laurel Thatcher. *The Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812*. New York: Random House, 1991.
- University of Toronto. *Report of the Standing Committee of the Faculty of Medicine on the Subject of Hospital Facilities*. Toronto: Rowsell & Hutchinson, University Printers, 1892.

#### University Calendars

McGill University, Montreal, Faculty of Medicine Annual Calendars, 1852-1894

Queen's University and College, Kingston, Faculty of Medicine Calendar, 1865-1866

University of Toronto, Faculty of Medicine Calendars, 1889-1922

### *Secondary Sources*

#### Unpublished Theses and Dissertations

Connor, James. "To Be Rendered Unconscious of Torture: Anaesthesia in Canada, 1847-1920." M.Phil.Thesis, University of Waterloo, 1983.

Elliott, Jayne. "'Endormez-moi!' An Early Twentieth-Century Obstetrical Practice in the Gatineau Valley, Quebec." MA Thesis, Carleton University, 1997.

Mennill, Sally Elizabeth. "Prepping the Cut: Caesarean Section Scenarios in English Canada, 1945-1970." PhD diss., University of British Columbia, 2012.

Walker, Katherine. "A Gendered History of Pain in England, circa 1620-1740." PhD diss., McMaster University, 2011.

#### Journal Articles and Book Chapters

Alberti, Samuel J.M.M. "Anatomical Craft: A History of Medical Museum Practice." In *The Fate of Anatomical Collections*. Eds.. Rina Knoeff and Robert Zwijnenberg. Burlington, VT: Ashgate, 2015.

Beaujot, Roderic and Kevin McQuillan. "Social Effects of Demographic Change: Canada, 1851-1981." *Journal of Canadian Studies* 21, no. 1 (Spring 1986): 57-69.

Bliss, Michael. "Privatizing the Mind: The Sundering of Canadian History, The Sundering of Canada." *Journal of Canadian Studies* 26, no. 4 (Winter 1991-1992): 5-17.

Bourke, Joanna. "Fear and Anxiety: Writing about Emotion in Modern History." *History Workshop Journal*. no. 55 (Spring 2003): 111-133.

-----, "Pain, Metaphor, Body, and Culture in Anglo-American Societies from the Eighteenth Century to the Present." *Rethinking History* (Published online 20 March 2014).

-----, "Pain Sensitivity: An Unnatural History from 1800 to 1965." *Journal of Medical Humanities* 35, no. 3 (2014): 301-319.

-----, "Pain, sympathy and the medical encounter between the mid eighteenth and the mid twentieth centuries." *Historical Research* 85, no. 229 (August 2012): 430-452.

- Comacchio, Cynthia. "Mechanomorphosis: Science, Management and 'Human Machinery' in Industrial Canada, 1900-1945." *Labour/Le Travail* 41 (Spring 1998): 35-67.
- , "The Rising Generation': Laying Claim to the Health of Adolescents in English Canada." *Canadian Bulletin of Medical History* 19, no. 1 (Spring 2002): 139-178.
- Davies, Megan J. "Mapping 'Region' in Canadian Medical History: The Case of British Columbia." *Canadian Bulletin of Medical History* 17 (2000): 73-92.
- Dodd, Diane. "Advice to Parents: The Blue Books, Helen MacMurchy, MD, and The Federal Department of Health, 1920-1934." *Canadian Bulletin of Medical History* 8 (1991): 203-230.
- Duffin, Jacalyn. "The Queen's Jews: Religion, Race, and Change in 20<sup>th</sup> Century Canada." *Canadian Journal of History* 49 (Winter 2014): 369-394.
- Elliott, Jayne. "A Negotiated Process: Outpost Nursing Under the Red Cross in Ontario, 1922-1984." In *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada*. Ed. Myra Rutherdale, 245-277. Montreal and Kingston: McGill-Queen's University Press, 2010.
- Gidney, R.D. and W.P.J. Millar. "Medical Students at the University of Toronto: A Profile." *Canadian Bulletin of Medical History* 13 (1996): 29-52.
- Gleason, Mona. "Embodied Negotiations: Children's Bodies and Historical Change in Canada, 1930 to 1960." *Journal of Canadian Studies* 34, no. 1 (1999): 112-138.
- Helps, Lisa. "Body, Power, Desire: Mapping Canadian Body History." *Journal of Canadian Studies* 41, no. 1 (Winter 2007): 126-150.
- Hide, Louise, Joanna Bourke and Carmen Mangion. "Perspectives on Pain." *19: Interdisciplinary Studies in the Long Nineteenth Century* 15 (2012).
- Hoberman, John. "The Primitive Pelvis: The Role of Racial Folklore in Obstetrics and Gynaecology During the Twentieth Century." In *Body Parts: Critical Explorations in Corporeality*. Eds. Christopher E. Forth and Ivan Crozier. Oxford: Lexington Books, 2005.
- Jasen, Patricia. "Race, Culture and the Colonization of Childbirth in Northern Canada." *Social History of Medicine* 10, no. 3 (1997): 383-400.
- Kealey, Linda, Ruth Pierson, Joan Sangster, and Veronica Strong-Boag. "Teaching Canadian History in the 1990s: Whose 'National' History Are We Lamenting?" *Journal of Canadian Studies* 27, no. 2 (Summer 1992): 129-130.

- Lansbury, Coral. "Gynaecology, Pornography and the Antivivisection Movement." *Victorian Studies* 28, no. 3 (Spring 1985): 413-437.
- Leavitt, Judith Walzer. "Birthing and Anaesthesia: The Debate over Twilight Sleep." *Signs* 6, no. 1 (Autumn 1980): 147-164.
- Leavitt, Judith Walzer and Whitney Walton. "'Down to Death's Door': Women's Perceptions of Childbirth in America." In *Women and Health in America*. Ed. Judith Walzer Leavitt. Madison: University of Wisconsin Press, 1984.
- MacDonald, Margaret. "Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada." *Medical Anthropology Quarterly* 20, no. 2 (June 2006): 235-256.
- Marland, Hilary. "Languages and Landscapes of Emotion: Motherhood and Puerperal Insanity in the Nineteenth-Century." In *Medicine, Emotion, and Disease, 1700-1950*. Ed. Fay Bound Alberti, Basingstoke: Palgrave Macmillan, 2006.
- Michaels, Paula. "Pain and Blame: Psychological Approaches to Obstetric Pain, 1950-1980." In *Knowledge and Pain*. Eds Esther Cohen, Leona Toker, Manuela Consonni and Otniel Dror, 231-255. Amsterdam: Rodopi, 2012.
- Millar, Wyn, Ruby Heap, and Bob Gidney. "Degrees of Difference: The Students in Three Professional Schools at the University of Toronto, 1910 to the 1950s." In *Learning to Practice: Professional Education in Historical and Contemporary Perspective*. Ottawa: University of Ottawa Press, 2005.
- Mitchinson, Wendy. "Agency, Diversity and Constraints: Women and Their Physicians, Canada, 1850-1950." In *The Politics of Women's Health: Exploring Agency and Autonomy*. Ed. Susan Sherwin. Philadelphia: Temple University Press, 1998.
- , "H.B. Atlee on Obstetrics and Gynaecology: A Singular and Representative Voice in 20<sup>th</sup>-Century Canadian Medicine." *Acadiensis*, XXXII, 2 (Spring 2003): 3-30.
- O'Connor, Eileen. "Constructing Medical Social Authority on Dress in Victorian Canada." *Canadian Bulletin of Medical History* 25, no. 2 (2008): 391-406.
- Oppenheimer, Jo. "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century." *Ontario History* 75 (1983): 36-60.
- Plamper, Jan. "The History of Emotions: An Interview with William Reddy, Barbara Rosenwein, and Peter Stearns." *History and Theory* 49 (May 2010): 237-265.
- Poovey, Mary. "'Scenes of an Indelicate Character': The Medical 'Treatment' of Victorian Women." *Representations* no. 14 (Spring 1986): 137-168.

- Porter, Roy. "The History of the Body Reconsidered." In *New Perspectives on Historical Writing*. Ed. Peter Burke. University Park, PA: Penn State University Press, 1992.
- , "The Patient's View: Doing Medical History from Below," *Theory and Society* 14, no. 2 (March 1985): 175-198.
- Roland, Charles G. "Ontario Medical Periodicals as Mirrors of Change." *Ontario History* 72, no. 1 (March 1980): 3-15.
- Rosenwein, Barbara. "Worrying about Emotions in History." *American Historical Review* 107, no. 3 (June 2002): 821-845.
- Schiebinger, Londa. "Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy." In *The Making of the Modern Body: Sexuality and Society in the Nineteenth-Century*. Eds. Catherine Gallagher and Thomas Laqueur, 42-82. Berkeley: University of California Press, 1987.
- Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *The Journal of American History* 60, no. 2 (September 1973): 332-356.
- Stanley, Heather. "Sairey Gamps, Feminine Nurses and Greedy Monopolists: Discourses of Gender and Professional Identity in the *Lancet* and the *British Medical Journal*, 1886-1902." *Canadian Bulletin of Medical History* 29, no. 1 (2012): 49-68.
- Theriot, Nancy M. "Women's Voices in Nineteenth Century Medical Discourse." *Signs* 19, no. 1 (Autumn 1993): 1-31.
- Treichler, Paula A. "Feminism, Medicine, and the Meaning of Childbirth." In *Body/Politics: Women and the Discourses of Science*, eds. Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth, 113-138. New York: Routledge, 1990.
- Valverde, Mariana. "'When the Mother of the Race is Free': Race, Reproduction, and Sexuality in First-Wave Feminism." In *Gender Conflicts: New Essays in Women's History*, eds. Franca Iacovetta and Mariana Valverde, 3-26. Toronto: University of Toronto Press, 1992.
- Weisz, George. "The Geographical Origins and Destinations of Medical Graduates in Quebec, 1834-1939." *Histoire sociale/Social history* 19, no. 37 (May 1986): 93-118.
- Wolf, Jacqueline H. "'Mighty Glad to Gasp in the Gas': Perceptions of Pain and the Traditional Timing of Obstetric Anesthesia." *Health* 6 (2002): 365-387.

Wood, Whitney. "'The Luxurious Daughters of Artificial Life': Female 'Delicacy' and Pain in Late-Victorian Advice Literature." *Canadian Bulletin of Medical History* 31, no. 2 (Fall 2014): 71-92.

-----, "'When I think of what is before me, I feel afraid': Narratives of Fear, Pain, and Childbirth in Late-Victorian Canada." In *Pain and Emotion in Modern History*. Ed. Rob Boddice, 187-203. Basingstoke: Palgrave Macmillan, 2014.

Yeniyurt, Kathryn. "When it Hurts to Look: Interpreting the Interior of the Victorian Woman." *Social History of Medicine* 27, no. 3 (August 2014): 1-19.

Young, Judith. "'Monthly' Nurses, 'Sick' Nurses, and Midwives in 19<sup>th</sup>-Century Toronto, 1830-1891." *Canadian Bulletin of Medical History* 21, no. 2 (2004): 281-302.

### Monographs

Adams, Mary Louise. *The Trouble with Normal: Postwar Youth and the Making of Heterosexuality*. Toronto: University of Toronto Press, 1997.

Alberti, Fay Bound, ed. *Medicine, Emotion, and Disease, 1700-1950*. Basingstoke: Palgrave MacMillan, 2006.

Anderson, Kim. *Life Stages and Native Women: Memory, Teachings, and Story Medicine*. Winnipeg, University of Manitoba Press, 2011.

Arnup, Katherine. *Education for Motherhood: Advice for Mothers in Twentieth Century Canada*. Toronto: University of Toronto Press, 1994.

Baillargeon, Denyse. *Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910-1970*. Translated by W. Donald Wilson. Waterloo: Wilfrid Laurier University Press, 2009.

Bending, Lucy. *The Representation of Bodily Pain in Late Nineteenth Century English Culture*. Oxford: Clarendon Press, 2000.

Boddice, Rob, ed. *Pain and Emotion in Modern History*. Basingstoke: Palgrave MacMillan, 2014.

Bourgeault, Ivy. *Push! The Struggle for Midwifery in Ontario*. Montreal and Kingston: McGill-Queen's University Press, 2006.

Bourgeault, Ivy Lynn, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving Midwifery*. Montreal and Kingston: McGill-Queen's University Press, 2004.

Bourke, Joanna. *Fear: A Cultural History*. London: Virago and Emeryville, 2005.

- , *The Story of Pain: From Prayer to Painkillers*. New York: Oxford University Press, 2014.
- Burnett, Kristin. *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta, 1880 to 1930*. Vancouver: University of British Columbia Press, 2010.
- Carter, Kathryn. *The Small Details of Life: Twenty Diaries by Women in Canada, 1830-1996*. Toronto: University of Toronto Press, 2002.
- Caton, Donald. *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present*. New Haven: Yale University Press, 1999.
- Comacchio, Cynthia. *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*. Montreal and Kingston: McGill-Queen's University Press, 1993.
- , *The Dominion of Youth: Adolescence and the Making of Modern Canada* Waterloo: Wilfrid Laurier University Press, 2006.
- Dally, Ann. *Women under the Knife: A History of Surgery*. New York: Routledge, 1999.
- Duffin, Jacalyn. *History of Medicine: A Scandalously Short Introduction*. Second Edition. Toronto: University of Toronto Press, 2010.
- , *Langstaff: A Nineteenth-Century Medical Life*. Toronto: University of Toronto Press, 1993.
- Dummitt, Christopher, *The Manly Modern: Masculinity in Postwar Canada*. Vancouver: University of British Columbia Press, 2007
- Dyck, Erika. *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice*. Toronto: University of Toronto Press, 2013.
- Forth, Christopher, and Ivan Crozier. *Body Parts: Critical Explorations in Corporeality*. Oxford: Lexington Books, 2005.
- Foucault, Michel. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books, 1977.
- , *The History of Sexuality Volume I: An Introduction*. New York: Vintage Books, 1978.
- Gagan, David and Rosemary Gagan. *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950*. Montreal and Kingston: McGill-Queen's University Press, 2002.



- Gammel, Irene, *The Intimate Life of L.M. Montgomery*. Toronto: University of Toronto Press, 2005.
- Gentile, Patrizia and Jane Nicholas, eds. *Contesting Bodies and Nation in Canadian History*. Toronto: University of Toronto Press, 2013.
- Gidney, R.D. and W.P.J. Millar. *Professional Gentlemen: The Professions in Nineteenth Century Ontario*. Toronto: University of Toronto Press, 1994.
- Gleason, Mona, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada*. Toronto: University of Toronto Press, 1999.
- , *Small Matters: Canadian Children in Sickness and Health*. Montreal and Kingston: McGill-Queen's University Press, 2013.
- Granatstien, J.L. *Who Killed Canadian History?* Toronto: Harper Collins, 1998.
- Gunn, Simon. *History and Cultural Theory*. London: Pearson Longman, 2006.
- Hunter, Kathryn Montgomery. *Doctors' Stories: The Narrative Structure of Medical Knowledge*. Princeton: Princeton University Press, 1993.
- Interpreting Women's Lives: Feminist Theory and Personal Narratives*. Ed. The Personal Narratives Group. Bloomington and Indianapolis: Indiana University Press, 1989.
- Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900 to 1950*. Vancouver: University of British Columbia Press, 1998.
- Kenny, Nicolas. *The Feel of the City: Experiences of Urban Transformation*. Toronto: University of Toronto Press, 2014.
- Korinek, Valerie. *Roughing It in the Suburbs: Reading Chatelaine Magazine in the Fifties and Sixties*. Toronto: University of Toronto Press, 2000.
- Laqueur, Thomas. *Making Sex: Body and Gender from the Greeks to Freud*. Cambridge: Harvard University Press, 1990.
- Leavitt, Judith Walzer. *Brought to Bed: Childbearing in America, 1750-1950*. New York: Oxford University Press, 1986.
- , *Make Room for Daddy: The Journey from the Waiting Room to the Birthing Room*. Chapel Hill: University of North Carolina Press, 2009.
- Lowe, Margaret A. *Looking Good: College Women and Body Image, 1875-1930*. Baltimore: Johns Hopkins University Press, 2003.

- Marland, Hilary. *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*. Basingstoke: Palgrave Macmillan, 2004.
- Martin, Emily. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press, 2001.
- McDiarmid, Norma J. *The Canadian Mothercraft Society: An Embodiment of Practical Idealism and Philanthropy*. St. Catharines: Lincoln Graphics, Inc., 1994.
- McKay, Ian. *The Quest of the Folk: Antimodernism and Cultural Selection in Twentieth-Century Nova Scotia*. Montreal and Kingston: McGill-Queen's University Press, 1994.
- McLaren, Angus. *Our Own Master Race: Eugenics in Canada, 1885-1945*. Toronto: McClelland & Stewart Inc., 1990.
- McPhedran, N. Tait. *Canadian Medical Schools: Two Centuries of Medical History, 1822 to 1992*. Montreal: Harvest House, 1993.
- McPherson, Kathryn. *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*. Toronto: University of Toronto Press, 2003.
- Michaels, Paula. *Lamaze: An International History*. Oxford and New York: Oxford University Press, 2014.
- Mitchinson, Wendy. *Body Failure: Medical Views of Women, 1900-1950*. Toronto: University of Toronto Press, 2013.
- . *Giving Birth in Canada: 1900-1950*. Toronto: University of Toronto Press, 2002.
- . *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1991.
- Morris, David B. *The Culture of Pain*. Berkeley: University of California Press, 1991.
- Moscoso, Javier. *Pain: A Cultural History*. Basingstoke: Palgrave MacMillan, 2012.
- Murphy-Lawless, Jo. *Reading Birth and Death: A History of Obstetric Thinking*. Bloomington: Indiana University Press, 1998.
- Nathoo, Tasnim and Aleck Ostry. *The One Best Way? Breastfeeding History, Politics, and Policy in Canada*. Waterloo: Wilfrid Laurier University Press, 2009.
- Nicholas, Jane. *The Modern Girl: Feminine Modernities, the Body, and Commodities in the 1920s*. Toronto: University of Toronto Press, 2015.
- Oakley, Ann. *The Captured Womb: A History of the Medical Care of Pregnant Women*. New York: Basil Blackwell, 1984.

- Opp, James. *The Lord for the Body: Religion, Medicine, and Protestant Faith Healing in Canada, 1880-1930*. Montreal and Kingston: McGill-Queen's University Press, 2005.
- Penny Light, Tracy, Barbara Brookes, and Wendy Mitchinson, eds. *Bodily Subjects: Essays on Gender and Health, 1800-2000*. Montreal and Kingston: McGill-Queen's University Press, 2015.
- Pernick, Martin. *A Calculus of Suffering: Pain, Professionalism, and Anaesthesia in Nineteenth Century America*. New York: Columbia University Press, 1985.
- Perry, Adele. *On the Edge of Empire: Gender, Race, and the Making of British Columbia, 1849-1871*. Toronto: University of Toronto Press, 2000.
- Porter, Roy. *The Greatest Benefit to Mankind: A Medical History of Humanity*. New York: W.W. Norton, 1999.
- Roland, Charles G. and Paul Potter. *An Annotated Bibliography of Canadian Medical Periodicals, 1826-1975*. Toronto: Hannah Institute for the History of Medicine, 1979.
- Roth, Michael S. *Memory, Trauma, and History: Essays on Living with the Past*. New York: Columbia University Press, 2012.
- Russet, Cynthia Eagle. *Sexual Science: The Victorian Construction of Womanhood*. Cambridge: Harvard University Press, 1989.
- Sandelowski, Margarete. *Pain, Pleasure and American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960*. London: Greenwood Press, 1984.
- Sawyer, Glenn. *The First 100 Years: A History of the Ontario Medical Association*. Toronto: Ontario Medical Association, 1980.
- Scarry, Elaine. *The Body in Pain: The Making and Unmaking of the World*. New York: Oxford University Press, 1985.
- Schuster, David G. *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869-1920*. New Brunswick: Rutgers University Press, 2011.
- Scull, Andrew. *Hysteria: The Disturbing History*. Oxford: Oxford University Press, 2009.
- Shepard, David A.E. *Watching Closely Those Who Sleep: A History of the Canadian Anaesthetists' Society*. Toronto: University of Toronto Press, 1993.
- Shorter, Edward. *Women's Bodies: A Social History of Women's Encounter with Health, Ill-Health and Medicine*. New York: Basic Books, 1982.

- Snow, Stephanie J. *Blessed Days of Anaesthesia: How Anaesthetics Changed the World*. New York: Oxford University Press, 2008.
- , *Operations without Pain: The Practice and Science of Anaesthesia in Victorian Britain*. New York: Palgrave MacMillan, 2006.
- Strange, Carolyn. *Toronto's Girl Problem: The Perils and Pleasures of the City, 1880-1930*. Toronto: University of Toronto Press, 1995.
- Strong-Boag, Veronica. *The New Day Recalled: Lives of Girls and Women in English-Canada, 1919-1939*. Markham: Penguin Books, 1988.
- Thomas, Mary. *Postwar Mothers: Childbirth Letters to Grantly Dick-Read, 1946- 1956*. Rochester: University of Rochester Press, 1997.
- Turner, Bryan. *The Body and Society: Explorations in Social Theory*. Oxford: Blackwell Publishing, 1984.
- Valverde, Mariana. *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland & Stewart, 1991.
- Wailoo, Keith. *Pain: A Political History*. Baltimore: Johns Hopkins University Press, 2014.
- Walden, Keith. *Becoming Modern in Toronto: The Industrial Exhibition and the Shaping of a Late Victorian Culture*. Toronto: University of Toronto Press, 1997.
- Warsh, Cheryl Krasnick. *Prescribed Norms: Women and Health in Canada and the United States since 1800*. Toronto: University of Toronto Press, 2010.
- Warsh, Cheryl Krasnick and Veronica Strong-Boag, eds. *Children's Health Issues in Historical Perspective*. Waterloo: Wilfrid Laurier University Press, 2005.
- Wertz, Richard W. and Dorothy C Wertz. *Lying-In: A History of Childbirth in America*. New York: MacMillan Publishing Co., 1977.
- Wolf, Jacqueline H. *Deliver Me From Pain: Anesthesia and Birth in America*. Baltimore: Johns Hopkins University Press, 2009.